Shay B. Dean, M.D.FACS
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Patient Information

Date: _____ To See Dr._____

Patient's Name:_____
Last First Middle

❑ Female ❑ Male DOB:_____ Age_____

Address:_____

City: _____State: _____Zip Code: _____

Telephone # - Home:_____Cellular:_____Work:_____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed Hgt:_____ Wght:_____

Social Security Number:_____Driver's License Number:_____

E-Mail Address:_____ Please check: ❑ Ok To Use ❑ Do Not Use

Employer Name: _____Occupation: _____

Employer Address:_____Telephone #:_____

Emergency Contact Name:_____ Relationship: _____

Home #:_____Cell#:_____ Work # _____

Spouse's Name: _____Phone # _____

Primary Care Physician: _____ Phone # _____

Referred By: _____May we thank them? _____

- **INSURANCE INFORMATION – Please Complete even if same as above**

Primary Insurance

Insurance Company: _____ Phone # _____

Address: _____
Street City State Zip

Subscriber ID:_____ Group # _____

Responsible Party: _____ DOB: _____ SS# _____

Relationship to Patient: _____ Contact # _____

Secondary Insurance

Insurance Company: _____ Phone # _____

Address: _____
Street City State Zip

Subscriber ID: _____ Group # _____

Responsible Party: _____ DOB: _____ SS# _____

Relationship to Patient: _____ Contact # _____

Is this office visit a work related injury? ___Yes ___No Date of Injury: _____

Workman's Compensation Insurance: _____ Phone # _____

Is this an auto or personal injury: ___Yes ___ No Date of Injury: _____

Attorney Name: _____ Phone # _____

Do you have an Advance Healthcare Directive? ____Yes ____ No
If you would like Advance Healthcare Information:
Caring Connections 1700 Diagonal Road, Suite 625, Alexandria VA 22314
www.caringinfo.org 800-658-8898

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT AUTHORIZATION:

I hereby authorize the above facility to release any information regarding services by the facility for insurance purposes. In addition I authorize and direct payment checks for benefits due me for the services rendered by the above named facility to be made directly to the facility, regardless of my insurance benefits, if any; I understand I am financially responsible for the fees for the services rendered.

_____ _____
Signature Date

What is your reason for visit?_____

Symptoms *Check (√) symptoms you currently have or have had in the past year*

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN only
☐ Chills	☐ Appetite poor	☐ Bleeding gums	☐ Breast lump
☐ Depression	☐ Bloating	☐ Blurred vision	☐ Erection difficulties
☐ Dizziness	☐ Bowel changes	☐ Crossed eyes	☐ Lump in testicles
☐ Fainting	☐ Constipation	☐ Difficulty swallowing	☐ Penis discharge
☐ Fever	☐ Diarrhea	☐ Double vision	☐ Sore on penis
☐ Forgetfulness	☐ Excessive hunger	☐ Earache	☐ Other
☐ Headache	☐ Excessive thirst	☐ Hay fever	**WOMEN only**
☐ Loss of Sleep	☐ Gas	☐ Hoarseness	☐ Abnormal Pap Smear
☐ Nervousness	☐ Hemorrhoids	☐ Loss of hearing	☐ Bleeding between periods
☐ Numbness	☐ Indigestion	☐ Nose bleeds	☐ Breast lump
☐ Sweats	☐ Nausea	☐ Persistent cough	☐ Extreme menstrual pain
MUSCLE/JOINT/BONE	☐ Rectal bleeding	☐ Ringing in ears	☐ Hot flashes
Pain, weakness, numbness in:	☐ Stomach pain	☐ Sinus problems	☐ Nipple discharge
☐ arms ☐ hips	☐ Vomiting	☐ Vision – Flashes	☐ Painful intercourse
☐ back ☐ legs	☐ Vomiting blood	☐ Vision - Halos	☐ Vaginal discharge
☐ feet ☐ neck	**CARDIOVASCULAR**	**SKIN**	☐ Other
☐ hands ☐ shoulders	☐ Chest pain	☐ Bruise easily	Date of last menstrual period_____
GENITO-URINARY	☐ High blood pressure	☐ Hives	
☐ Blood in urine	☐ Irregular heart beat	☐ Itching	Date of last Pap Smear_____
☐ Frequent urination	☐ Low blood pressure	☐ Change in moles	
☐ Lack of bladder control	☐ Poor circulation	☐ Rash	Have you had a mammogram? _____
☐ Painful urination	☐ Rapid heart beat	☐ Scars	
	☐ Swelling of ankles	☐ Sore that won't heal	Are you pregnant?
	☐ Varicose veins		Number of children _____

Conditions *Check (√) symptoms you currently have or have had in the past year*

☐ AIDS	☐ Chemical dependency	☐ High cholesterol	☐ Prostate problem
☐ Alcoholism	☐ Chicken Pox	☐ HIV positive	☐ Psychiatric care
☐ Anemia	☐ Diabetes	☐ Kidney disease	☐ Rheumatic fever
☐ Anorexia	☐ Emphysema	☐ Liver disease	☐ Scarlet fever
☐ Appendicitis	☐ Epilepsy	☐ Measles	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Migraine headaches	☐ Suicide attempt
☐ Asthma	☐ Goiter	☐ Miscarriage	☐ Thyroid problems
☐ Bleeding disorders	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis
☐ Breast lump	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Heart disease	☐ Mumps	☐ Typhoid Fever
☐ Bulimia	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hernia	☐ Pneumonia	☐ Vaginal infection
☐ Cataracts	☐ Herpes	☐ Polio	☐ Venereal disease

Medications *List medications you are currently taking*

Allergies

Pharmacy Name_____ Phone_____

Health History

Family History *Fill in health information about your family*

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if your blood relatives had any of the following: *Disease*	*Relationship to you*
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical dependency	
					Diabetes	
					Heart disease, strokes	
Sisters					High blood pressure	
					Kidney disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications, if any

Health Habits

Check (√) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates: _____

Serious Illness/Injuries	**Date**	**Outcome**
Are you having pain at this time?	**Yes** **No**	
What level of pain? (1-10)		

Occupational

Check (√) if your work exposes you to the following:

	Stress	
	Hazardous substances	
	Heavy lifting	
	Other	
Occupation:		

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature Date

_____

Reviewed by Date

Shay B. Dean, M.D.
SUNSET HILLS SURGERY CENTER

PATIENT PRIVACY

Our surgery center is committed to securing the privacy of your health information. We have posted our **Notice of Privacy** in the reception area. You are not required to read this notice. However we would like your acknowledgement that you have been notified that we practice a privacy policy.

Signature _____ Date _____

Shay B. Dean, M.D.

PHOTOGRAPHY RELEASE & CONSENT

I consent to the taking of photographs by Dr. Dean or his designee of parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Dean. I further authorize Dr. Dean or one of his designees to release to the American Society of Plastic Surgeons (ASPS) such photographs.

I understand that photography is important in planning and evaluating surgery, and I give permission for photographs to be taken before, during, and after my surgery. I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of ASPS and may be retained by ASPS or released by ASPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods. I also authorize Dr. Dean to use my photographs and case information in like manner, through his professional associations, the not for profit American Society for Aesthetic Surgery, and the California Society of Plastic Surgeons

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the released of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Dean. I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I may revoke this authorization in writing at any time. If I do not revoke this authorization, it will expire ten years from the date written below.

I authorize the use of my photographs, videotapes, and case information in the following commercial educational settings: Dr. Dean's office patient education material; Dr Dean's File of pre-and post-operative patient photographs available to prospective patients for viewing in the office; newspaper and magazine articles in which Dr. Dean participates; television programs in which Dr. Dean participates; Dr. Dean official practice web site or web page and lectures and multimedia presentations given by Dr. Dean for the general public.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1966 (HIPPA). I further understand that because the above organizations are not receiving the information in the capacity of a health care provider, the information described above may no longer be protected by HIPPA.

I release and discharge Dr. Dean, ASPS and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claims for payment. **I certify that I have read the above Authorization and Release and fully understand its terms.**

_____ _____

Signature **Date**