



PATIENT DEMOGRAPHIC SHEET

Appointment date: _____

Patient name: _____

Birth date: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____

Contact Information:

May we contact your cell phone? Yes No Cell phone: _____

May we contact you at home? Yes No Home phone: _____

If yes, may we leave a message? Yes No

May we contact you at work? Yes No Work phone: _____ Ext. _____

May we contact you via email? Yes No Email address: _____

I am interested in learning about special events and exclusive offers.

Employer: _____

Occupation: _____

Employer address: _____

City: _____ State: _____ Zip: _____

Emergency contact person: _____

Relationship: _____

Contact address: _____

City: _____ State: _____ Zip: _____

Home phone: _____

Cell phone: _____

Work phone: _____

Family physician: _____

Phone: _____

Dermatologist: _____

Phone: _____

Who referred you to us? Please check any and all that apply.

Physician
Name: _____

Word of mouth/Friend/Staff member
Name: _____

Q Med Spa

Print Publication
 D&C
 Other _____

Seminar
Title/topic: _____

Online
 Internet search
 Facebook
 Other website: _____

Television
Name of station/channel: _____

Radio
Name of station: _____

Billboard

Phonebook
(Please turn over)

The web is an integral way patients learn about our practice. Do you participate in any of the following?
(Check all that apply)

Google+ Yelp Facebook Twitter Pinterest RealSelf Instagram

Medical Review Sites: If yes, which one(s)? _____

Blogging: If yes, where can we see it? _____

What website(s) did you find helpful in researching our practice or the procedure? _____

INSURANCE INFORMATION ~ REQUIRED

Policy holder's name: _____ Relationship: _____

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Aetna | <input type="checkbox"/> Preferred Care | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Blue Cross / Blue Shield | <input type="checkbox"/> United | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> Blue Choice | <input type="checkbox"/> Via Health | <input type="checkbox"/> Other: _____ |

Contract #: _____ Group #: _____ Contact person: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Insurance phone: _____

FISCAL POLICIES

It is the policy of The Quatela Center for Plastic Surgery that payment for all office services are due on the date of service. We accept various forms of payment including cash, personal checks, money orders, and Visa, MasterCard, Discover, and American Express. According to standard practice, full payment for cosmetic surgery is required three weeks in advance of surgery.

Cancellation of appointments must be made 48 hours prior to scheduled date or service fees will be charged to the patient.

I authorize payment of medical benefits to Vito C. Quatela, M.D. and William J. Koenig, M.D., PLLC for services rendered and release any medical information necessary to process the payment claim.

Signature of Insured or Authorized Person

Date



PATIENT INFORMATION SHEET

Name: _____

Date: _____

What area(s) of the face and/or body are you interested in having cosmetically or functionally improved?

- Forehead / Midface
- Lower Face / Neck
- Eyes
- Nose
- Chin
- Ears
- Skin Texture

- Breasts
- Abdomen
- Buttock
- Thighs
- Veins
- Hair
- Other _____

Description of facial/body concerns: _____

Is your family/significant other aware of your cosmetic concern(s)? Yes No

Does your family/significant other support your desire for cosmetic surgery or enhancement? Yes No

Please check any fears you have regarding surgery/medical procedures:

- Anesthesia Surgical outcome Opinions of others Unsuccessful past procedures Pain Cost
- Recovery time Complications Natural-looking results Current medical issues Other: _____

Please check the strengths you possess that will make this procedure a success for you:

- Positive outlook Personal motivation Support from significant other Self-confident
- Family support Successful career Disciplined, goal-oriented Confidence in surgeon
- Good timing for procedure, i.e.: retirement Other: _____

Please check the potential opportunities having a procedure/surgery will provide for you:

- Improved self-esteem Improved self-confidence Advancement in career/career change Getting married
- New relationship opportunities Correction of cosmetic flaws Physical appearance reflect mental image of self
- Increased comfort with intimacy Life event, i.e.: child's wedding, school reunion Other: _____

Are there any other questions or concerns you would like answered at this time?

MEDICAL EVALUATION

Updated August 2014

Please check all past and present medical conditions.

CARDIOVASCULAR:

- High blood pressure
- High cholesterol
- Coronary artery disease
- Heart attack(s)
- Stent placement
- Irregular beat/Palpitations
- Murmur/Valve prolapse
- Peripheral vascular disease
- Pacemaker
- Abnormal EKG
- Stroke/TIA(s)

PULMONARY:

- Asthma
- Shortness of breath
- Chronic cough
- Chronic lung disease
- Home oxygen use
- Sleep apnea/CPAP

HEMATOLOGICAL:

- History of blood clots
- Anemia
- Bleeding/Clotting disorder
- Blood transfusion

NEUROLOGICAL:

- Nerve damage
- Facial paralysis/weakness
- Seizure disorder/convulsions
- Spinal/Back disorder
- Dizziness/Vertigo
- Peripheral neuropathy
- Migraine headaches

HEPATIC:

- Cholecystitis
- Cirrhosis
- Hepatitis

MUSCULOSKELTAL:

- Muscle weakness
- Rheumatoid arthritis
- Osteoarthritis
- Degenerative joint disease
- Osteoporosis

ENDOCRINE:

- Diabetes
Type 1 Type 2
- Insulin dependent
- Hypoglycemia
- Thyroid disease

EYES/EARS/NOSE/THROAT:

- Glasses/contacts
- Blurred/double vision
- Cornea problems
- Glaucoma
- Cataracts
- Thyroid eye disease
- Dry eyes
- Hearing loss – R L
- Hearing aids – R L
- Difficulty breathing by nose
- Nasal allergies
- Frequent sinus infections
- Previous nasal injury
- Dentures/Oral appliance

GASTROINTESTINAL:

- Heartburn/GERD
- Ulcers
- Irritable bowel disease
- Diarrhea
- Constipation
- Crohns/Colitis
- Pancreatitis

RENAL/GU:

- Kidney disease/failure

- Dialysis
- Kidney stones
- Kidney infections
- Frequent UTIs
- Enlarged prostate

DERMATOLOGICAL:

- Cold sores/herpes
- Rosacea
- Radiation to face/neck
- Scarring/keloid formation
- Acne
- Eczema
- Psoriasis

IMMUNOLOGICAL/

INFECTIOUS DISEASES:

- Autoimmune disorder:

- Tuberculosis
- HIV/AIDS
- STD

REPRODUCTIVE:

- Pregnant
- Breastfeeding
- Past pregnancies: # _____
- C-section(s)
- Contraception use
Type: _____
- Pre/Post menopause

(CONTINUED ON NEXT PAGE)

(continued)

PSYCHIATRIC:

- Anxiety
- Depression
- Bipolar disorder
- Claustrophobia
- Body dysmorphia
- Received psychiatric treatment/hospitalization
- Drug/Alcohol dependency
- Dementia/Alzheimer's

ONCOLOGICAL:

- Breast Cancer
- Basal cell cancer
Site: _____
- Squamous cell cancer
Site: _____
- Melanoma
Site: _____
- Other cancer:
Site: _____

List **all** drug / food / environmental / tape allergies:

List **all** medications you are taking, including prescription, over-the-counter, vitamins, and herbal supplements:

Are you or have you recently taken any medication containing Aspirin? Yes No

Please list name of medication and dosage: _____

Have you been on Accutane therapy in the last 18 months? Yes No

Have you taken any steroid preparations over the past year? Yes No

List all past surgeries (including cosmetic surgery) with year:

Have you ever had any surgical complications? Yes No

Please describe: _____

Height: _____ Weight: _____ Ideal Weight (if not at ideal): _____

Exercise Frequency (check one): ≤1x/week 2-4x/week 5-7x/week

Marital Status: Single Long-term partner Married Divorced Widow(er)

Are you currently pregnant or breastfeeding? Yes No

List delivery dates of past pregnancies: _____

Do you use any nicotine products? Yes No If yes, how much per day _____

Did you ever smoke? Yes No For how many years: _____ Year you quit: _____

Exposure to 2nd hand smoke on a daily basis? Yes No

Do you consume alcoholic beverages? Yes No If yes, how much per day _____

Race: Asian/Pacific Islander African American Caucasian
 Hispanic or Latino Middle Eastern/Arab Native American

Ethnicity: _____

Primary Language Spoken: English Spanish French Other: _____

FAMILY HISTORY:

	Condition	Afflicted Family Member(s)	Comments
<input type="checkbox"/>	Adopted		
<input type="checkbox"/>	Abnormal Bleeding/Clotting		
<input type="checkbox"/>	Anesthesia Problems		
<input type="checkbox"/>	Autoimmune Disorders		
<input type="checkbox"/>	Cancer		
<input type="checkbox"/>	Cleft Lip/Palate		
<input type="checkbox"/>	Diabetes		
<input type="checkbox"/>	Hearing Loss		
<input type="checkbox"/>	Heart Disease		
<input type="checkbox"/>	High Blood Pressure		
<input type="checkbox"/>	Kidney Disease		
<input type="checkbox"/>	Liver Disease		
<input type="checkbox"/>	Skin Disease		
<input type="checkbox"/>	Substance Abuse		