GUERRA
Plastic Surgery Center

Aldo Guerra, MD, FACS
8765 E. Bell Road, Suite 104
Scottsdale, AZ 85260
480-970-2580 Office
480-513-2175 Fax

# PATIENT REGISTRATION FORM

| Today's Date | | | |
|---|---|---|---|

**Patient Information**

| | | | |
|---|---|---|---|
| Name | | Birth Date | Age |
| Address | | Gender | Female Male |
| City, State Zip | | Spouse | Married Separated Divorced Widowed |
| Email | | Name | |
| Occupation | | Occupation | |
| Employer | | Employer | |

**Patient's Contact List**

| Call Order | Type | Phone Number | OK to leave detailed message |
|---|---|---|---|
| 1 | Home Work Cell Other | | Yes No |
| 2 | Home Work Cell Other | | Yes No |
| 3 | Home Work Cell Other | | Yes No |
| 4 | Home Work Cell Other | | Yes No |

**Emergency Contacts**

| Name | Phone Number | Relationship |
|---|---|---|
| | | |
| | | |

**HIPAA Authorization**

Under HIPAA Guidelines, I authorize you to discuss my protected health information for any purpose with the following person(s).

| Name | Phone Number | Relationship |
|---|---|---|
| | | |
| | | |

**Referral Information**

How did you hear about Guerra Plastic Surgery Center or Dr. Aldo Guerra?

If you searched on the Internet, what keyword(s) did you search for?

**Signature**

I agree that the above information is correct as listed or changed as indicated.

Signature ______________________ Date ______________

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# NEW PATIENT HISTORY FORM

| Today's Date | | Name | |
|---|---|---|---|

## Consultation Information

| Date of Last Physical Exam | |
|---|---|
| Doctor who performed Exam | |
| Do you have a primary care doctor? No Yes | |

Ethnicity (check all that apply)

African American | Asian | Caucasian
Hispanic | Native American | Other: ____________

What procedures are you interested in?

| | | | |
|---|---|---|---|
| Breast Augmentation | Tummy Tuck | Body Lift | BOTOX® |
| Breast Lift | Liposuction | Arm Lift | Dermal Fillers |
| Breast Reduction | Mommy Makeover | | |
| Breast Implant Exchange | Brazilian Butt Lift | Other: ____________ | |

| What would you like to discuss at your consultation? | |
|---|---|
| How long have you considered surgical correction? | |

Have you consulted other doctors? No Yes

Have you discussed surgery with your family? No Yes

Is your family supportive? No Yes

## Allergies and Medications

Are you **currently taking any medication**? No Yes

| Medication | Dosage | For how long | Reason / Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you **currently taking any vitamins or herbal supplements**? (e.g. green tea, St. John's Wart)? No Yes

| Vitamin / Supplement | Dosage | For how long | Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you **ALLERGIC** to or have any adverse reaction to any **MEDICATION**? No Yes

| Medication | Reaction / Comments |
|---|---|
| | |
| | |
| | |
| | |

Are you **ALLERGIC** to or have any sensitivity to:

| | | | |
|---|---|---|---|
| Iodine / Dyes / Shellfish | No Yes | Tape / Adhesive | No Yes |
| Latex | No Yes | Creams / Lotions | No Yes |

## Social History

| | | | | | | |
|---|---|---|---|---|---|---|
| Do you smoke? | No | Socially | 1-6 cig. per day | 7 cig.-1 pack per day | More than 1 pack per day | |
| Have you quit smoking? | No | Less than 3 mo. ago | 3-6 mo. ago | 6-12 mo. ago | More than 1 yr. ago | |
| Do you drink alcoholic beverages? | No | 1-2 per week | 3-5 per week | 6 or more per week | | |
| Do you drink caffeinated beverages? | No | 1-2 per day | 3-4 per day | 5 or more per day | | |
| Do you use "recreational" drugs? | No | Marijuana | Cocaine | Heroin | Meth | Other: ____________ |

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## Medical History

| Height | ft. in. | Weight | lbs. | BMI | | Blood Type | |
|---|---|---|---|---|---|---|---|

Have you been diagnosed with any of the following MEDICAL CONDITIONS? None

| Medical condition | YES | Details | Medical condition | YES | Details |
|---|---|---|---|---|---|
| Blood Disorder / Clotting Disorder | | | Breast Cancer | | |
| Heart Disease / Stroke | | | Prostate Cancer | | |
| Hypertension / High Blood Pressure | | | Lung Cancer | | |
| Migraine Headaches | | | Other Cancer | | |
| Diabetes | | | HIV / AIDS | | |
| Depression / Mental Illness | | | Venereal Disease | | |
| Endometriosis | | | Herpes | | |
| Polycystic Ovarian Syndrome | | | Arthritis | | |
| Hyperthyroid / Hypothyroid | | | Allergies | | |
| Asthma | | | Excessive Scarring | | |
| Hepatitis | | | Delayed or Poor Healing | | |

For Women:

No Yes Is your **Mammogram** current? Results: Normal Abnormal ____________________

No Yes Have you ever had an **ultrasound** of the breast?

No Yes Have you ever had a Breast Biopsy or Fine Needle Aspiration? Date: ____________________

No Yes Have you ever had a lump in the breasts?

No Yes Have you ever had any Breast Discharge?

## Surgical and Hospitalization History

Have you had any surgeries? No Mesotherapy Lipo Dissolve Laser Lipo

| Month/Year | Reason | Surgery | Findings |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever been **HOSPITALIZED** other than for pregnancy or surgery? No

| Month/Year | Reason | Hospital Name | Findings / Outcome |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever been to the EMERGENCY DEPARTMENT? No

| Month/Year | Reason | Hospital Name | Findings / Outcome |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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## Review of Systems

Please mark any of the following disorders YOU currently have or had issues with: None

| Constitutional | Musculo-Skeletal | Lung / Cardiovascular |
|---|---|---|
| Increase in appetite | Lupus erythematous | High Blood Pressure |
| Decrease in appetite | Tremors | Low Blood Pressure |
| Weight gain | Rheumatoid arthritis / Joint pain | Mitral Valve Prolapse |
| Weight loss | Auto-immune disorder | Rheumatic Fever |
| Difficulty concentrating | Problems with smell | Heart / Vascular Disease |
| Hot flashes / Night sweats | Other: | Lung Disease |
| Fatigue | | Chronic Bronchitis |
| | | Asthma |
| **Central Nervous System** | **Hematological** | **Endocrine** |
| Dizziness | Anemia | Excessive hair growth |
| Seizures / Convulsions | Blood clotting disorder / Bleeding tendency | Heat intolerance |
| Head Trauma | Sickle cell anemia or trait | Cold intolerance |
| Chronic / Migraine Headaches | Other: | Unexplained rush |
| Poor sense of smell | | Excessive thirst or hunger |
| **EENT** | **Genitourinary** | Diabetes Mellitus (high blood sugar) |
| Problems with head, eyes, ears, nose, throat | Bladder infections (cystitis) | Hypoglycemia (low blood sugar) |
| Visual Problems | Kidney infections | Thyroid disorder |
| Other: | Other kidney or bladder problems | Nipple discharge |
| | **Gastrointestinal** | Other: |
| | Hepatitis / Liver Disease | |
| | Stomach or Intestinal problems, Ulcers | |

## Checklist

| # | No | Yes | Question |
|---|---|---|---|
| 1. | No | Yes | Do you consider yourself a healthy person? |
| 2. | No | Yes | Do you have hay fever, nasal allergies or asthma? |
| 3. | No | Yes | Do you have or have you had corrective lenses for your vision? |
| 4. | No | Yes | Do you have frequent pains in your chest? |
| 5. | No | Yes | Has a doctor ever said you have “heart trouble”? |
| 6. | No | Yes | Do you have or have you had chest or lung problems? |
| 7. | No | Yes | Have you ever had liver, gall bladder, or yellow jaundice problems? |
| 8. | No | Yes | Do you experience poor circulation in your fingers or toes? |
| 9. | No | Yes | Do you have frequent skin irritations, infections, or rashes? |
| 10. | No | Yes | Have you ever had fever blisters, cold sores, or canker sores on your face, lips, or mouth? |
| 11. | No | Yes | Has any part of your body ever been paralyzed or numb? |
| 12. | No | Yes | Are you frequently sick or ill? |
| 13. | No | Yes | Do you worry about your health? |
| 14. | No | Yes | Have you ever been treated for anemia or any problems with your blood? |
| 15. | No | Yes | Have you ever taken hormones? |
| 16. | No | Yes | Have you ever been treated for abuse of alcohol or drugs? |
| 17. | No | Yes | Do you ususally feel unhappy or depressed? |
| 18. | No | Yes | Are you considered a nervous person? |
| 19. | No | Yes | Have you ever had a nervous breakdown? |
| 20. | No | Yes | Have you ever received treatment for a nervous breakdown? |
| 21. | No | Yes | Are you easily upset or irritated? |
| 22. | No | Yes | Do you tend to hold a grudge when someone angers you? |
| 23. | No | Yes | Have you ever considered consulting a psychiatrist or psychologist? |
| 24. | No | Yes | Do you have any other medical problems that have not been covered? |
| 25. | No | Yes | Do you accept the fact that every medical / surgical treatment is associated with risks and unknowns? |
| 26. | No | Yes | Do you consent to and authorize the recommended diagnostic, medical, surgical, anesthetic and other diagnostic services that the clinic deems beneficial while you are under our care? |

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## Family History

Does anyone in your family have any of the following medical conditions? None I do not know my family history

| Medical Condition | Mother | Father | Brother | Sister | Grandmother (maternal) | Grandfather (maternal) | Grandmother (paternal) | Grandfather (paternal) |
|---|---|---|---|---|---|---|---|---|
| Blood Disorder / Clotting Disorder | | | | | | | | |
| Heart Disease | | | | | | | | |
| Stroke | | | | | | | | |
| Hypertension / High Blood Pressure | | | | | | | | |
| Diabetes | | | | | | | | |
| Depression / Mental Illness | | | | | | | | |
| Endometriosis | | | | | | | | |
| Hyperthyroid | | | | | | | | |
| Hypothyroid | | | | | | | | |
| Migraine Headaches | | | | | | | | |
| Asthma | | | | | | | | |
| Hepatitis | | | | | | | | |
| Breast Cancer | | | | | | | | |
| Prostate Cancer | | | | | | | | |
| Lung Cancer | | | | | | | | |
| Other Cancer | | | | | | | | |
| Arthritis | | | | | | | | |
| Excessive Scarring | | | | | | | | |
| Delayed or Poor Healing | | | | | | | | |

## Patient Notes / Comments

## Verification of Information

I agree that the above information is correct as listed.
I have answered the questions to the best of my ability and verify that all of my answers are truthful.

Signature ______________________ Date ______________________

Print Name ______________________

**Aldo Benjamin Guerra, MD, FACS**
Board Certified Plastic Surgeon

8765 E. Bell Rd., Ste 104
Scottsdale, AZ 85260
480-970-2580
MyFaceAndBody.com

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my **treatment** and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain **payment** from third-party payers.
- Conduct normal **healthcare operations** such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(es) above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

________________________ ________________________ ____________
Patient's Name (Print) Patient Signature Date

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

________________ ___________ _______________________________________
Date Initials Reason

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# NOTICE OF PRIVACY PRACTICES

**This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: **treatment, payment and health care operations**.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this Notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or filing a complaint, please contact the following federal agency:

U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

(202) 619-0257

Toll Free: 1-877-696-6775

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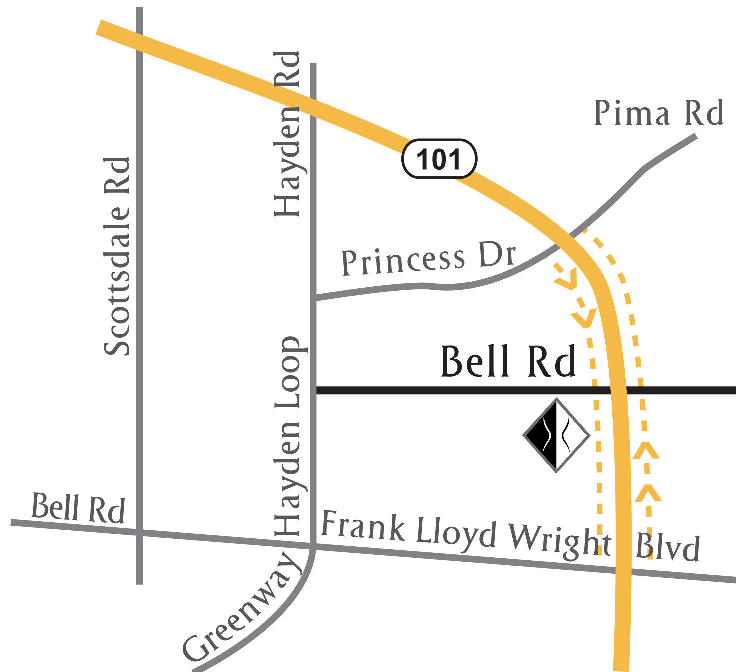


**Heading 101 East**

Exit #36 PRINCESS / PIMA. Stay in the middle lane.
Proceed straight at the 1st light PRINCESS / PIMA.
Proceed straight at the 2nd light BELL.
Make a quick right turn into the Desert Fairways parking lot.

**Heading 101 North**

Exit #38 FRANK LLOYD WRIGHT. Stay in the middle lane.
Proceed straight at the 1st light FRANK LLOYD WRIGHT.
Make a left on your 2nd light BELL.
Make an immediate left turn as you go under the freeway.
Make a quick right turn into the Desert Fairways parking lot.

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