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Pedro M. Soler, M.D.
Aesthetic Plastic Surgery

Patient Information (Informacion Del Paciente)

PLEASE PRINT ALL INFORMATION CLEARLY (FAVOR DE ESCRIBIR TODA INFORMACION CLARAMENTE)

LEGAL Last Name *(Apellido legal)* ..... LEGAL First Name *(Nombre legal)* ..... MI *(Inicial)* .....

Date of Birth *(Fecha de Nacimiento)* ..... Age *(Edad)* ..... Sex *(Sexo)* ..... Race *(Raza)* .....

Social Security # *(seguro social del paciente)* ..... Email .....

Would you like to receive email notifications? Yes ☐ *No* ☐

Please indicate if there is a Nickname you prefer.
.....

Profession *(Profeción)* .....

Marital Status (Estado Marital):

☐ Single *(Soltero)* ☐ Married *(Casado)* ☐ Separated *(Separado)* ☐ Divorced *(Divorciado)* ☐ Widowed *(Viudo)*

Address *(Dirección)* ..... City *(Ciudad)* .....

State *(Estado)* ..... Zip Code *(Codigo Postal)* ..... Home # *(# de la casa)* .....

Cell Phone *(# de cellular)* ..... Work Phone *(# del trabajo)* .....

If Patient is a Child (Si el Paciente es Un Niño):

Mother's Name *(Nombre de la Madre)* ..... SS # *(# de seguro social)* ..... DOB *(Fecha de Nacimiento)* .....

Father's Name *(Nombre del Padre)* ..... SS # *(# de seguro social)* ..... DOB *(Fecha de Nacimiento)* .....

MUST BE FILLED OUT!! PERSON TO NOTIFY IN CASE OF EMERGENCY *(EN CASO DE EMERGENCIA PERSONA A NOTIFICAR)*

Emergency Contact Name *(Nombre en caso de emergencia)* ..... Relationship to patient *(Relación al paciente)* ..... Phone # *(Teléfono)* .....

Referring Physician (Médico Que Refiere El Caso)

Name *(Nombre)* ..... Address *(Dirección)* .....

Phone *(Teléfono)* ..... Fax .....

OFFICE USE ONLY:

Pre-Op Photos .....

Post-Op Photos .....

Patient's Signature or Legal Guardian/: *(firma)* .....

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Primary Care Physician (Doctor Primario)

Name *(Nombre)* .....

Address *(Dirección)* .....

.....

Phone *(Teléfono)* ..... Fax .....

May we provide the above physicians with a copy of Dr. Soler's office note(s): ☐ Yes ☐ No *If yes, please sign below.*

Podemos enviarles a sus médicos copia de las notas de la oficina de Dr. Soler: ☐ *Si* ☐ *No Si podemos, porfavor firme abajo.*

Signature *(Firma)* .....

THIS INFORMATION IS NECESSARY, PLEASE COMPLETE
(ESTA INFORMACIÓN ES NECESARIA, POR FAVOR LLENE)

Insurance Information (Información del Seguro Médico)

Primary Insurance Company ..... Subscriber .....
(Compañia de Seguro Primario) *(Subcripción a Nombre de)*

Subscriber's SS# ..... Subscriber's DOB ..... Relationship to patient .....
(Seguro Social del Asegurado) *(fecha de nacimiento)* *(Relación al Paciente)*

Group#/Name ..... Policy / ID # .....
(Grupo #/Nombre) *(# de polisa o de Identificación)*

IS THIS INFORMATION TRUE AND CORRECT REGARDING YOUR PRIMARY INSURANCE? Yes ..... *(please initial)*
(ESTA INFORMACIÓN ES VERDADERA Y CORRECTA EN LO QUE SE REFIERE NUESTRO PRINCIPAL SEGURO?) *(Iniciales)*

Secondary Insurance Information (Información del Seguro Médico Secundario)

Primary Insurance Company ..... Subscriber .....
(Compañia de Seguro Primario) *(Subcripción a Nombre de)*

Subscriber's SS# ..... Subscriber's DOB ..... Relationship to patient .....
(Seguro Social del Asegurado) *(fecha de nacimiento)* *(Relación al Paciente)*

Group#/Name ..... Policy / ID # .....
(Grupo #/Nombre) *(# de polisa o de Identificación)*

IS THIS INFORMATION TRUE AND CORRECT REGARDING YOUR SECONDARY INSURANCE? Yes ..... *(please initial)*
(ESTA INFORMACIÓN ES RERDADERA Y CORRECTA EN LO QUE SE REFIERE NUESTRO SEGURO SECUNDARIO? *(Iniciales)*

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Agreement to guarantee payment/assign benefits/release information

The undersigned agrees, whether as agent or patient, to accept full responsibility for all charges for services agreed to on behalf of the patient and by the physician. The lender signed agrees to pay all charges at time of service or upon receipt of statement. I understand that I am responsible for any costs incurred and the reasonable attorney fees and/or court costs. This agreement is valid for the services provided on this date and for all future visits and services until revoked by me.

I authorize third parties to pay directly to the physician's insurance benefits due for services rendered on behalf of the patient.

I authorize the physician to furnish my insurance company and/or other responsible third party payer or their representatives any medical information necessary to process this claim.

PATIENT and/or GUARDIAN DATE

Agreement to guarantee payment for in or out of network/unauthorized coverage

I understand that the services I am requesting by Dr. Pedro M. Soler on (date) ..... may be out of network or unauthorized by my health insurance (HMO/PPO/Indemnity/Auto Insurance/Worker's Compensation, etc., coverage). Dr. Soler's office staff does not verify coverage prior to your appointment prior to my appointment. Therefore, in the case that my insurance is out of network; or my insurance coverage has lapsed for any reason whatsoever, any/all services rendered by Dr. Soler are not covered, I understand that I will be held solely responsible for all charges.

I also understand that since this possibility exists, any payment(s) made on the part of the insurance company may and/or will be made directly to me. I, in turn, agree to sign over the payment(s) to Dr. Pedro M. Soler. I also understand that I have given the proper insurance informtaion with regard to coordination of benefits. If an overpayment recovery should occur due to incorrect information, I will be held soley responsible for charges.

PATIENT and/or GUARDIAN DATE

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CONSENT FOR IRREVOCABLE NON-ASSIGNMENT (COSMETIC PATIENTS)

I, _____, hereby authorize Dr. Pedro M. Soler to provide care for me, as it will be explained to me in the additional consent documents. I understand the procedure(s) I seek are cosmetic in nature, not medically necessary, and therefore would be fraudulent and unethical for Dr. Soler to submit to any insurance company for coverage. I will be fully informed of the financial costs of having Dr. Soler provide surgical care for me and accept those terms. I further understand that Dr. Pedro M. Soler will not accept insurance for this cosmetic procedures(s). My consent to have Dr. Pedro M. Soler provide care and not accept assignment from any insurance company, managed care provider or other coverage source is irrevocable and final. I understand I will be fully responsible for the surgical fees for the surgery I seek.

_____ _____

PATIENT/GUARDIAN DATE

Patient's Name: _____ Date of Birth: _____

CONSENT FOR PHOTOGRAPHY

I further authorize Dr. Soler to use my photographs for professional medical purposes deemed necessary to your insurance carrier for medical necessity or pre-determination letters.

Patient's Name: _____ Date of Birth: _____

_____

SIGNATURE

I further consent my photos to be used for the following purposes: (please initial if you consent)

Medical publications and/or Lay publications. _____

Medical and/or Patient education. _____

During lectures to medical or lay groups for training and learning purposes. _____

_____ _____

PATIENT SIGNATURE DATE

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HIPPA Compliance Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I have been provided the opportunity to review the "Notice of Patient Privacy Information Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to review the "Notice" prior to acknowledging this consent,
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment, or healthcare operations

Restrictions:

I request the following restrictions to the use or disclosure of my health information:

.....

May discuss treatment, payment or healthcare operation with the following persons:

(Please check all that apply) ☐ Spouse ☐ Your Children ☐ Relatives ☐ Other ☐ Parents

Please list the names and relationships, if you checked "Relatives" or "Others" above:

1. ..... 3. .....

2. ..... 4. .....

Additional: .....

Messages or Appointment Reminders: (Please check all that apply)

May we leave a message on your answering machine at home ☐ or at work ☐. **Do not leave a message** ☐.

May we leave a message with someone at your **home** using the doctor's name or the practice name: ☐ Yes ☐ No

May we leave a message with someone at your work using the doctor's name or the practice name: ☐ Yes ☐ No

Messages will be of a non-sensitive nature, such as, Dr's name, appointment time & date.

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers, labs, and/or other individuals or agencies as permitted or required by state or federal law.

I fully understand and accept the information provided by this consent.

....

Signature *Print name of person signing* *Date*

*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations. ☐ Yes ☐ No

For Office Use Only

☐ Patient refused to sign the consent form. (Date) ..... Witnessed by: .....

☐ Restrictions were added by the patient (see restrictions listed above)

☐ "Consent form" received and reviewed by ..... on (date)..... placed in MR (date).....

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Name: .....
Height: .....
Weight: .....

Please answer ALL questions.

What is your reason for today's visit? .....

When did this problem start? .....

Where is this problem located? .....

What makes this problem worse? .....

Are there any other symptoms associated with this problem? ☐ Yes ☐ No If yes, describe: .....

.....

Please check all that apply

Constitutional
- ☐ Unwanted weight changes
- ☐ Recent fevers
- ☐ Weakness
- ☐ Fatigue
- ☐ Unable to exercise

Eye
- ☐ Wear glasses/contacts
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Recent changes in vision
- ☐ Double vision

Ears,Nose,Mouth,Throat
- ☐ Changes in hearing
- ☐ Ear discharge
- ☐ Ringing of the ears
- ☐ Dizziness
- ☐ Nose bleeds
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Sore gums
- ☐ Bleeding gums

Cardiovascular
- ☐ Chest pain
- ☐ Fast heart rate
- ☐ Palpitations
- ☐ High blood pressure
- ☐ Blood clots in the veins of the legs
- ☐ Pain in the legs when walking

Respiratory
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Blood in sputum
- ☐ Cough
- ☐ Tuberculosis

Gastrointestinal
- ☐ Decreased appetite
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in stools
- ☐ Rectal bleeding

Genitourinary
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in the urine
- ☐ Testicular pain
- ☐ Wake up during the night to urinate

Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Arthritis
- ☐ Gout
- ☐ Back pain

Integumentary
- ☐ Rashes
- ☐ Dry skin
- ☐ Jaundice
- ☐ Bruising
- ☐ Breast tenderness
- ☐ Breast swelling
- ☐ Breast lumps
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Nipple retraction

Neurological
- ☐ Faintness
- ☐ Blackouts
- ☐ Seizures
- ☐ Paralysis
- ☐ Memory loss
- ☐ Tremors

Psychiatric
- ☐ Insomnia
- ☐ Nervousness
- ☐ Depression
- ☐ Mood swings
- ☐ Anxiety
- ☐ Lack of energy

Endocrine
- ☐ Thyroid trouble
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Increased appetite
- ☐ Increased urination
- ☐ Excessive sweating

Ever had general anesthesia? ☐ Yes ☐ No *If yes did you have any side effects or reactions?* .....

.....

List previous medical problems:

Medical Problems:	Year Diagnosed:

List past Surgeries

Surgical Procedures:	Year:

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List all medications you are currently taking

please make sure to include any over the counter medications such as Aspirin or Aspirin products, any Diet pills, St. John's Wart, Ginseng, Ibuprofen, Advil, Motrin, etc.:

Drug	Dose	Frequency

Birth Control Pills ☐ Yes ☐ No Method of Birth Control: .....

How many Pregnancies: ..... Live .....

ALLERGIES

Penicillin: ☐ Yes ☐ No Effect/s: .....

Novocain/ Xylocaine: ☐ Yes ☐ No Effect/s: .....

Latex: ☐ Yes ☐ No Effect/s: .....

Other Medications: ..... Effect/s: .....

..... Effect/s: .....

..... Effect/s: .....

..... Effect/s: .....

..... Effect/s: .....

Social History (Check all that apply):

☐ Tobacco
If checked, how many packs per day....., *for* ..... *years. If stopped, year stopped* .....

☐ Alcohol
If checked, ☐ *socially,* ☐ *binge on weekends*

☐ Coffee,tea,soda
If checked, How many cups per day.....

☐ Recreational drugs
If checked, Type..... *How much* ..... *How often* ..... *How long* ..... *yrs. If stopped, year stopped* .....

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Family History (Check all that apply):

Paternal: Grandparents

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Father ☐ Alive (Age __) ☐ Deceased (Age__) ☐ Unknown

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Maternal: Grandparents

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Mother ☐ Alive (Age __) ☐ Deceased (Age__) ☐ Unknown

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Brothers:

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Sisters:

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Children:

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Patient's Name: ..... Date of Birth :.....

Patient/Guardian ..... Date ..... Physician's Signature ..... Date.....