Paragon Plastic Surgery & Med Spa
Mark A. Bishara M.D., P.A.

New Patient Medical History - Cosmetic Surgery

Allergy to medication:____

Full Name ____________________________________ Date ______________

Address __________________________City ______________________State _____ Zip ____________

*Email address __________________________________SSN# _________________________

Date of Birth: ____________________Age: _______ Gender:________

Home phone _________________ Cell_____________________Work__________________

May we contact you at home, on your cell, at work, thru face time, or Skype?____________

Marital Status ____________________ Number of children__________

Occupation/Employer________________________________ Ht______ Wt_________ (lbs)

Race: Caucasian African American Hispanic Asian Other

Emergency Contact: ____________________Ph________________cell _________________

How did you hear of our office? Friend, TV, Yellow Pages, Newspaper, Magazine, Radio Other

Reason for visit, why are you here today?______________________________________

Who is your primary care physician? ____

How much time do you spend in the sun? Tanning booth?

Do you wear sunscreen? How often? SPF/Brand

How would you describe your skin? _________________________________

Always burn, sometimes tan, Never bum, always tan
Do you smoke? _________ Do you drink alcohol? ___________
Are you pregnant? ____________ Are you breast feeding?________________
Amount of water you drink a day :____________glasses.

List all medications you are presently taking:

____

____

Check all medications that apply:

bHcg (beta hCG)
Birth Control
Testosterone
Minoxidil
Aldactone
Retin-A Renova

Accutane
NSAIDS / Aspirin
Tetracycline
DHEA
Blood Thinners

Steroids
Thyroid
Chemotherapy
Antidepressants

Vitamin E
Herbals
Acne Medication

Previous Cosmetic Facial Treatments, Surgery, Resurfacing, or Laser Treatments:

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Please list any other medical conditions?

___Acid Peels Date:_________________

____Botox Date: __________

____Fillers / Injectables Date: __________

___Tattoo/Perm Makeup Date: __________

___Waxing Date: __________

___Facial Plastic Surgery Date: ________

___Laser Surgery Date: __________

____Microdermabrasion Date: ____

____

____

Have you ever had the following conditions:

AIDS
Anemia
Arthritis
Asthma
Blood disease
Blood transfusion
Cardiac problems
Chemotherapy
Chronic headaches
Dermatitis
Diabetes
Dizziness

Epilepsy
Eczema
Fainting
Fibromyalgia
Hay fever
Heart disease
Hepatitis
High blood pressure
Infection (active)
Immune disorders
Keloid scars
Kidney disease

Liver disease
Lupus
Melanoma
Nervous disorder
Pacemaker
Psoriasis
Radiation treatment
Respiratory disorder
Rosacea
Skin cancer
Skin disease
Sinus problems
Stomach problems
Stroke

Thyroid problems
Tuberculosis (TB)
Urinary problems
Ulcers
Venereal disease

****Cold Sore / Fever Blister**

Frequency < 1/year

Frequency 1-3/year

Frequency >4-1-/year

I have answered the above questions truthfully and will notify you of any changes in medications and physical conditions.

Patient Signature:______________________________ **Date:** ________________

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Information Request Form -- Cosmetic Surgery I Aesthetic Services

Please let us know if you would like to receive additional information regarding any of the following Cosmetic Surgery and Aesthetic Services.

Skin Care, Laser Treatments and Non-surgical Aesthetics

___Skin Care Products for Acne Control
___Skin Care Programs for Sun Damage and Wrinkles
___Skin Care Programs for Blotchy skin
___Chemical Peels for Facial Skin Improvement
___Botox /Filler Treatments for Facial Lines and Wrinkles
___Laser Treatment for Wrinkles
___Laser Treatment for Facial Veins
___Laser Treatment for Hair Reduction
___Laser Treatment for Brown Spots
___Other

Cosmetic Surgery Procedures

___Facial Cosmetic Surgery (Face lift, eyelid lift, fat transfer, lip augmentation)
___Cosmetic Breast Surgery (Breast augmentation, breast reduction, breast lift, male gynecomastia)
___Body Contouring Surgery (Abdominoplasty, laser liposuction--Lipotherme, liposuction)
___Post Bariatric Surgery (Body lift, arm lift, thigh lift, panniculectomy, removal of skin folds)
___Hair Restoration Surgery / Hair Transplant Surgery (Men and Women)
Hand Rejuvenation

___Other

Thank you. A staff member will contact you soon to offer further assistance.

Bishara Cosmetic Surgery & Hair Restoration

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Consent To Treatment, Release of Information, Financial Agreement

CONSENT TO TREATMENT: I understand and acknowledge that Texas Law provides that if any health care worker is exposed to my blood or other bodily fluid, this practice may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including HIV, with or without my consent. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of this surgical practice. I understand the results of tests taken under these circumstances are confidential and do not become part of my medical record. I give my consent to Dr. Mark A. Bishara or his designees to perform or administer all tests and treatment that, in the judgment of Dr. Mark A. Bishara, is advisable during my visit to this surgical practice.

RELEASE OF INFORMATION: I authorize to release/obtain information contained in my financial and medical records, including diagnosis and test results, to/from (a) any of my treating practitioners, (b) my insurance company or health care plan or its representative, or its agents or independent contractors or (c) any other person or entity that is responsible for paying or processing for payment any portion of my medical treatment bill or (d) to any person or entity for the purposes of administration, billing, collecting, and quality assessment and risk management or to any hospital, nursing home, home health agency or to any healthcare institution to which I am transferred. I understand this consent applies to all records created in the course of and relating to my care. I release and agree to hold harmless the surgical practice of Dr. Mark A. Bishara and his representatives and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand this surgical practice cannot be responsible for use or redisclosure of information by third parties.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: In consideration for the medical and surgical services to be or have been rendered to me, I agree to pay for those services. I agree to assign to Dr. Mark Bishara , the benefits under my insurance policies or prepaid health care plan or other reimbursement source. I acknowledge that any balance not covered or paid by such policy or plan is my legal and financial responsibility. I acknowledge that I am aware this practice does not charge interest for late payments. I acknowledge that I am aware that any balance not covered or paid after 120 days, will be turned over to a collection agency and this practice will initiate termination of my patient-physician relationship as described by Texas Law. I acknowledge that any billing-related complaint will be directed to the billing compliance officer. I acknowledge and I am aware that cosmetic surgery procedures are not covered by the benefits under my insurance company and Dr. Mark A. Bishara does not accept insurance reimbursements for cosmetic surgery procedures and all charges related to cosmetic surgery are my own financial responsibility. I acknowledge that I am aware the policy of billing practices and the policy of charity care are both available upon request.

THIS IS A LEGAL CONSENT, FINANCIAL AGREEMENT, AND ASSIGNMENT OF BENEFITS FORM. PLEASE READ IT CAREFULLY AND BE SURE YOUR QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING.

Signature :______________________ Name:_________________________

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PHOTOGRAPHIC CONSENT

Date___________Full Name_____________________________________

I, hereby authorize and consent that any and all photographs, images, or videos taken by Dr. Mark A. Bishara at Bishara Cosmetic Surgery Center of any part of my body, whether originals or reproductions, may be utilized for such purposes as he may desire in connection with his research, writing, professional activities, and may be used, exhibited and published through any medium whatsoever as part of or in connection with his research, writing, and professional activities, even though such use may be for advertising purposes or purposes of trade. This consent is not retractable, either by oral or written means.

I certify that I have read and understand the aforementioned and sign my name below giving authorization and consent to the foregoing and any photographs, image, or videos taken for future surgeries.

Date: _________ Patient Signature:______________________________________

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Acknowledgement of Receipt of Notice of Privacy Practices

Health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice maybe changed at any time. I may obtain a revised copy of the Notice by requesting one at this office.

Do you have any restrictions as to how we contact you?___________________________

Are you willing to be contacted via Face time or Skype?___________________________

If Yes: Face time ID:______________________ or Skype ID:________________________

Special Instructions:____

____

Signature: ____________________________________

Patient Name: _________________________________

Date:______________

*** If signed by a personal representative, please state your authority to act for (Name)**

THIS SPACE TO BE USED BY PRACTICE ONLY

Patient Acknowledged Notice of Privacy Practices on Form Provided and Returned Signed Copy.
Accepted _______________________Denied_____________________

If Refuse to Sign, Document Reason in Chart: _____________________

Note: Cannot refuse to see patient if patient refused to sign Acknowledgement

Signed Acknowledgement ________________

Accepted or Denied ____________________

Name of Employee Documenting ___________________________

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