



# 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 2<sup>nd</sup> 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		