Quatela
CENTER FOR
PLASTIC SURGERY

# 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**
- ☐ **Online**
  - ☐ Internet search
  - ☐ Facebook
  - ☐ Other website: _____
- ☐ **Print Publication**
  - ☐ D&C
  - ☐ Other_____
- ☐ **Seminar**
  Title/topic: _____
- ☐ **Radio**
  Name of station: _____
- ☐ **Billboard**
- ☐ **Television**
  Name of station/channel: _____
- ☐ **Phonebook**

(Please turn over)



973 East Avenue | Rochester, New York 14607 | 585.244.1000 | Quatela.com

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: _____

☐ Aetna ☐ Preferred Care ☐ Medicaid

☐ Blue Cross / Blue Shield ☐ United ☐ Medicare

☐ Blue Choice ☐ Via Health ☐ 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

Quatela
CENTER FOR
PLASTIC SURGERY

# 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?

_____

_____

**Please check <u>all</u> 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 |
|---|---|---|---|
| ☐ | Adopted | | |
| ☐ | Abnormal Bleeding/Clotting | | |
| ☐ | Anesthesia Problems | | |
| ☐ | Autoimmune Disorders | | |
| ☐ | Cancer | | |
| ☐ | Cleft Lip/Palate | | |
| ☐ | Diabetes | | |
| ☐ | Hearing Loss | | |
| ☐ | Heart Disease | | |
| ☐ | High Blood Pressure | | |
| ☐ | Kidney Disease | | |
| ☐ | Liver Disease | | |
| ☐ | Skin Disease | | |
| ☐ | Substance Abuse | | |