Patient Registration and History

Patient Name ______________________________, ____________________ ____________________
Last First Middle

Preferred Phone #s

Cell __________________________ Home ________________________ Other ____________________

Email address ______________________________ OR ____

Local Address ____
City ______________________________ **State** ___________ **Zip** ________________
Billing Address ____
City ______________________________ **State** ___________ **Zip** ________________

Emergency contact ____________________________ Phone ________________ Relationship ____________

Social Security # ____________________ **Sex Male Female Birth Date** _______________ **Age** ______
Married ____ **Single** ____ **Widowed** ____ **Separated**_____ **Divorced**_____ **Height**______ **Weight**______

Occupation ____ **Employer** ______________________________
Eye Doctor ____ **Primary Physician** ______________________

Referred by ____

Reason for Visit ____

Allergies to medicine: No_____ Yes______ Please list ____

____

Current Medications/Vitamins:____

____

Are you a smoker? (circle) Yes / No Ex-Smoker? Yes / No

How much are (were) you smoking? _____________ How long ? _______________ Quit how long ago? _____________

How much alcohol do you drink? (circle) <1 drink/day 1 - 2 drinks/day >2 drinks/day

Please circle all of the following medical conditions you now have or have had in the past: high blood pressure / bleeding tendency / problems scarring or delayed healing / cancer / hepatitis / HIV / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / thyroid disease / depression / mental illness / drug or alcohol addiction /

other ____________________ Is there any possibility that you might be pregnant at this time? Yes / No

List all surgeries that you have had (include cosmetic/plastic surgeries)_______________________________________

____

I agree the above information is accurate to the best of my ability.

Signature ______________________________________

Patient #________ Date ______________

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

NAME ______________________________ BIRTHDATE ________________

SS # ___________________

I understand that as part of my healthcare, this organization originates and maintains health 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 many healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and surgical 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 care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations- and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand the office's notice of Privacy Practices.

__________________________________ ___________

Patient Signature or Legal Representative Date

____

Witness Signature

:401 PGA Blvd., Suite 150
'alm Beach Gardens, FL 33410
561) 624-9995 Fax
561) 624-7777
vww.HassPlasticSurgery.com
vww.FreezeMyFatFL.com

MEDICAL AUTHORIZATION

FOR PATIENT INFORMATION

I, ____________________ hereby authorize any hospital, physician, medical practitioner, clinic, or other medical or medically related facility, pharmacy, insurance company or government agency to disclose or furnish to Dr. Hass, or their representatives, any and all information with respect to any illness, injury, medical history, dental history, consultations, prescriptions, treatment or benefits and copies or all applicable records that may be requested.

I also request that ______________________, relationship, ________________ be allowed medical information about my condition. I understand that a photo copy of this authorization is to be considered as valid as the original.

Patient's Name ________________________________

Date of Birth _________ SS # ____________________

Patient Signature_______________________________ Date___________

2401 PGA Blvd., Suite 150
Palm Beach Gardens, FL 33410
(561) 624-9995 Fax
(561) 624-7777
www.HassPlasticSurgery.com
www.FreezeMyFatFL.com

HASS
Plastic Surgery & MediSpa

My consultation today is for ____________________________________.
We offer a multitude of cosmetic procedures. If there is something else you might be interested in learning more about, please check below.

FOR FACE

____ Eyes – (upper/lower eyelids - blepharoplasty)
____ Brow lift
____ Face lift / Neck lift
____ Rhinoplasty - Nose or tip reshaping
____ Ear pinning (otoplasty)
____ Ear Lobe repair / reduction
____ Chin Augmentation

FOR BREASTS

____ Breast Augmentation ____ Saline ____ Silicone
____ Implant Exchange /Deflation ____ Saline ____ Silicone
____ Mastopexy - Breast Lift ____ Remove Implants
____ Breast Reduction ___ Female ___ Male (Gynecomastia)

FOR BODY

____ Liposuction ____ Tummy Tuck ___ Mommy Makeover
____ BBL ____ Fat Transfer ____ Hand Rejuvenation
____ Vaginal Rejuvenation ____Labiaplasty ___ ThermiVa®
____ CoolSculpting®

FOR SKIN

____ BOTOX® or Dysport® ___ Other
____ Injectable Fillers (i.e. Juvéderm®, Restylane®, Sculptra®)
____ Lasers for pigmentation, redness, scars, brown spots)
____ Microneedling/ PRP
____ Chemical Peels & Clinical Skin Care
____ Permanent Makeup (for lips, brows, eye liner, other)
____ Lash Growth ____ Latisse™

Advertising Tracking Sheet

Thanks for this opportunity to meet you.
We would appreciate it if you would tell us how you heard of the doctors and our office.

Newspapers

____ Palm Beach Post
____ Palm Beach Daily News - *Shiny sheet*

Magazines

____ Palm Beach Illustrated
____ Jupiter Magazine

Other Media

____ Internet Search or Sites (__ Google __ Yelp ___Real Self __ASPS __Vitals/Dr Info __Product Sites)
____ Hass Website
____ Social Media (be specific ________________________________)
____ Billboard
____ E-mail newsletter
____ Signage on our building (Live in the area - Come to the plaza frequently
____ Radio
____ Television

OR Word of Mouth

____ Friends & / OR Relatives ______________________
____ A Previous Hass patient(s) ____________________
____ Another Doctor or Dentist OR their staff __________________
____ Salon / Make up Counter / other ____________________
____ Attended one of our seminars or events
____ Our staff________________

If you have seen our ads or any editorial about our office, what specifically did you like or dislike?____
____
____