Roseville Facial Plastic Surgery

David J. Kiener, M.D., F.A.C.S | Jonathan M. Sykes M.D., F.A.C.S.

Name_____

Mailing Address_____

City_____State_____Zip_____

Home Phone_____Cell Phone_____

Work Phone_____

Date of Birth_____Age_____

Marital Status_____

Spouse Name_____

Parent Name (if patient is a minor) _____

PATIENT EMPLOYER INFORMATION

Employer Name_____Telephone#_____

Address_____

Occupation_____

EMERGENCY INFORMATION

In the event of an emergency, please notify_____

Telephone number_____Relationship_____

1. How did you hear about our office? _____
2. Would you be interested in receiving mailings of future specials and events via email or US mail? Please circle one
3. E-Mail Address:_____

Signature_____Date_____

Certified by the American Board of Facial Plastic and Reconstructive Surgery ~ Facial Aesthetic and Reconstructive Surgery

~ Laser Procedures and Skin Cares

Two Medical Plaza, Suite 225 . Roseville, CA 95661 . p 916.773.0935 . f 916.782.5992

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Aesthetic Patient Questionnaire

Referral source: Internet_____ Seminar _____ Other _____

Personal Goals:

The reason for my consultation today is:

_____

_____

I have the following concerns/interest:

General Aging of my skin / face_____

Fine lines and wrinkles_____

Facial appearance / proportion_____

Facial / body irregular veins_____

Hair removal_____

Irregular scars_____

Sun damage skin_____

Have you ever had any of the following treatments?

Aesthetic of cosmetic surgery? _____

_____

Botox or similar treatment? _____

Injected or implanted fillers? _____

Skin resurfacing (chemical peel, dermabrasion, laser resurfacing)? _____

_____

Light-based treatments? (IPL, fractional)_____

What do you use for daily skincare? (Prescriptive, over the counter)_____

_____

Do you use Accutane? _____ Smoke? (now / ever) _____ Drink alcohol? _____

Thank you for allowing us to assess and determine a course of treatment just for you!

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Roseville Facial Plastic Surgery recognizes and respects the fact that all patients have the right to inspect and obtain a copy of their own records (Protected Health Information).

With my consent RFPS may use and disclose and Protected Health Information (PHI) about myself (or child) to carry out treatment, payment, to collect any outstanding charges, and healthcare operations. Please refer to RFPS's notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the notice of Privacy Practices prior to signing this consent. Our office reserves the right to revise its notice of Privacy Practices at anytime.

With my consent, this office my mail to my home or other designated location or leave a message on the voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, and other healthcare operations, such as appointment reminders, insurance items, payment items and any call pertaining to my clinical care, including laboratory results and information among others.

With my consent, the doctor's office may mail to home or other designated location any items that assist the practice in carrying out treatment, payment, and other healthcare operations, such as appointment reminder cards, patient statements, and any other information regarding my (or my child's) healthcare as long as they are marked "Personal and Confidential".

With my consent, RFPS may e-mail any information regarding my (or my child's) healthcare, treatment, payment, and appointments to me.

I have the right to request that RFPS restricts how it uses and discloses my healthcare information to carry out treatment and payment. The practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this forms, I am and authorizing RFPS to use and disclose my PHI to carry out treatment, payment, and other healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, RFPS may decline to provide treatment to my child or me.

_____I have read and received a copy of the brochure Privacy Practices.

_____ _____

Print Patient Name Date of Birth

_____ _____

Signature of Patient or Legal Guardian Date

The doctor my release PHI to: ___Spouse ___Partner

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