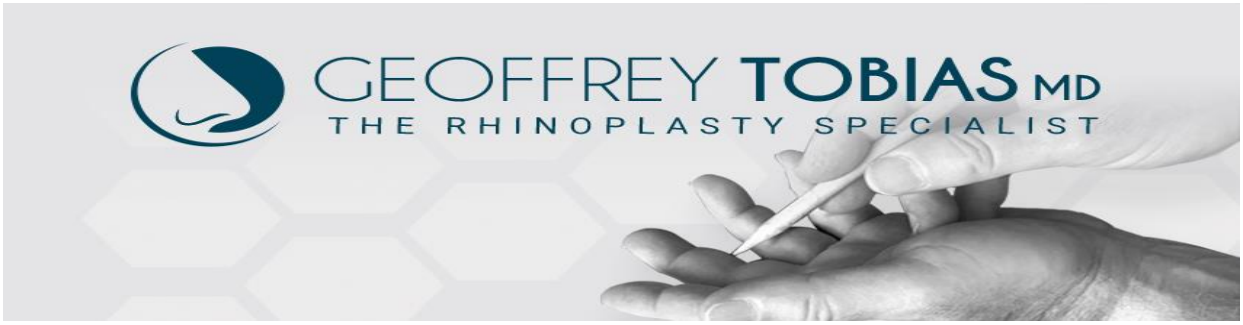

Welcome to Our Office

Date: _____

Last Name: _____ First Name: _____

Address: _____

City, State & Zip Code: _____

Date of Birth: _____ Age: ____ Social Security Number: _____

Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced

Cell Phone: _____ Home Phone: _____

E-Mail Address: _____

Patient Employer/Occupation: _____

Emergency Contact: _____ Contact Cell: _____

Contact Relationship to Patient: _____

Insurance Company: _____

Insurance ID #: _____ Group #:_____

Insurance Address: _____

Policy Holder Name: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Policy Holder Employer/Occupation: _____

Relationship to Insured: ___ Self ___ Spouse ___ Dependent

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____

Medical History

Have you ever had surgery before, including plastic surgery? If yes, please list surgeries including approximate year of surgery.

_____

_____

Have you ever had any traumatic injury to your nose (i.e. broken nose from fight, accident, or sports related injury)?

_____

_____

Please list any medical problems for which you have received or are currently receiving care for.

_____

_____

Please list all medications and herbal/vitamins supplements you take.

_____

Do you take aspirin, any aspirin related products, or blood thinners? If so, please list.

_____

Do you have any drug allergies? _____. If yes, please list: _____

Do you smoke? _____. When was the last time you smoked? _____

Do you drink alcohol? ____ No ___ Yes

Please write yes if you ever had a problem with any of the below.

___Asthma	___Thyroid	___Anesthesia
___Diabetes	___Heart Murmur	___Depression
___Easy Bruising/Bleeding	___Palpitations	___Seizures
___High Blood Pressure	___Heart Arrhythmias	___Epilepsy
___Kidney Disease	___Mitral Valve Prolapse	___Poor Healing
___Liver Disease	___Heart Attack	___Acne

___Other. Please describe: _____.

What were the factors that influenced you to come see Dr. Tobias? i.e.: internet, Instagram, specific website, friends and/or family, etc, referral:
_____.

If applicable, do you have a particular timeframe (month or week) that you would like adhere to for your surgery? _____.

List in priority the things that concern you about your nose, what you would like corrected, and your realistic desires:
_____
_____.

Have you had any previous nasal surgery to improve breathing or correct appearance? If so, please list all procedures including minor revisions and their approximate dates.
_____
_____.

Has cartilage from the inside of your nose (the septum) been removed to correct a deviated septum? ____No. ____Yes. ____ I'm not sure.

Has any cartilage or bone from other parts of your body (ribs, ear, skull, etc.) been used as a graft to improve the shape of your nose? ____No. ____Yes. ____ I'm not sure.

Who performed the surgeries? _____

I consent to the photographing of my pre-operative, operative, and post-operative condition, and procedures performed for clinical use. I am over 18 years of age.

_____ _____

Patient Signature (must be over 18) Date

Because part of the process in selecting a cosmetic surgeon is dependent upon patients viewing examples of the surgeon's work, *we ask that you consider* granting permission to use your photos in any or all of the following ways. *Please initial next to any or all that apply*.

_____ Sharing your photos with other patients.

_____ Use for professional instruction at meetings or online educational seminars.

_____ "Before and After" surgery examples for our website and social media accounts.

_____ Videos for use on our website and social media accounts.

_____ _____

Patient Signature (must be over 18) Date

Insurance Authorization & Assignment

It is your responsibility to know your insurance carriers requirements and to advise us in advance before you receive any service. You must understand that if you receive a service that your insurance company doesn't allow, you will be responsible for the fee. These are not our regulations, they are your insurance company's regulations. If you have any questions, please call the Member Services phone number listed on your ID card. *I hereby authorize Dr. Geoffrey W. Tobias to furnish information to insurance carriers concerning my illness and treatment, and hereby assign him to all payments for medical service rendered.*

_____ _____

Patient Signature (must be over 18) Date

Patient/HIPAA Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you to choose to refuse to disclose your Personal Health Information (PHI). If you chose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form or would like a copy of this HIPAA consent, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

_____ _____

Patient Signature (must be over 18) Date