Bellissimo
PLASTIC SURGERY & MEDI SPA

Registration Form

PATIENT NAME (Last, First, Middle Name):				Maiden Name	DATE:
Marital Status S - M - W - DIV - SEP	Date of Birth:	Age:	Sex:	Race: [ ] Caucasian [ ] Asian [ ] Hispanic [ ] Indian [ ] African American	
Street Address: [ ] Permanent [ ] Temporary		City State Zip		Home Phone:	
Patient's Employer:		Occupation: (Student []Part-time []Full-time)		Business Phone:	
Social Security Number:		Cell Phone Number			
Emergency Contact:		Relationship:		Telephone Number:	

**Email will be used for most all communication from our office. It may also be used to keep you informed of all promotions, discounts, education, etc This information will NOT be shared.*

Email Address:

-- IF PATIENT IS A MINOR OR STUDENT PLEASE FILL OUT THIS SECTION --

Mother's Name:	Full Address:	Home Phone Number:	Social Security Number:
Mother's Birth Date:	Mother's Employer:	Occupation:	Business Phone Number:
Father's Name:	Full Address:	Home Phone Number:	Social Security Number:
Father's Birth Date:	Father's Employer:	Occupation:	Business Phone Number:

INSURANCE (PLEASE PROVIDE A COPY OF INSURANCE CARD – FRONT &BACK)

PRIMARY	NAME OF INSURANCE	INSURANCE ADDRESS PHONE #	
	SUBSCRIBER ID #/CLAIM #	GROUP #	
	SUBSCRIBER	DATE OF BIRTH	RELATIONSHIP
	SUBSCRIBER ADDRESS		
	EMPLOYER	OCCUPATION	SOCIAL SECURITY #
SECONDARY	NAME OF INSURANCE	INSURANCE ADDRESS PHONE #	
	SUBSCRIBER ID #/CLAIM #	GROUP #	
	SUBSCRIBER	DATE OF BIRTH	RELATIONSHIP
	SUBSCRIBER ADDRESS		
	EMPLOYER	OCCUPATION	SOCIAL SECURITY#

PHARMACY INFORMATION:

Name of Pharmacy:_____ **Address:**_____

Phone:_____ **Fax:** _____ _____

If applicable: Date of ACCIDENT or INJURY_____ Due to : [ ] Work [ ] Auto [ ] Other

I request that payment of authorized insurance benefits be made to Bellissimo Plastic Surgery LLC for any services furnished to me by that physician or supplier. I authorize the release of medical information (and/or photographs) about me needed to determine the benefits or the benefits payable for related services to my insurance company and its agents.

SIGNATURE:_____ **DATE:**_____

Revised: 7-31-23

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Medical History

Patient Name: _____ D.O.B:_____Age: ___

Stated Height:_____ Stated Weight:_____

Referring Physician (Address & Phone): _____

Primary Care Physician (Address & Phone): _____

How did you hear about us? _____

Other Physicians you see (example: Heart, Lung, Endocrine specialist):

_____M.D. Type: _____

_____M.D. Type: _____

Reason for visit: _____

Have you ever seen another surgeon for the same problem or concern? ☐ Yes ☐ No

Past Medical History: (Please circle yes or no)

Neurological:

Migraine/ Headache	Yes	No	Brain Aneurysm / Head Injury	Yes	No
Fainting	Yes	No	Macular Degeneration	Yes	No
Stroke / TIA / Paralysis	Yes	No	Retinal Detachment	Yes	No
Seizures	Yes	No	Blindness	Yes	No
Glaucoma	Yes	No	Other:	Yes	No

Pulmonary:

Asthma	Yes	No	Deep Vein Thrombosis	Yes	No
Aspiration	Yes	No	Pulmonary Embolism	Yes	No
Sleep Apnea	Yes	No	Pulmonary Hypertension	Yes	No
Pneumonia / Bronchitis	Yes	No	Lung Cancer / Tuberculosis (TB)	Yes	No
Emphysema / COPD	Yes	No	Other:	Yes	No

Cardiac:

High Blood Pressure	Yes	No	Congestive Heart Failure	Yes	No
Elevated Cholesterol	Yes	No	Heart Murmur / Valve Disease	Yes	No
Angina/Chest pain	Yes	No	Pacemaker / Defibrillator	Yes	No
Heart Attack	Yes	No	Rheumatic Fever / Heart Infection	Yes	No
Irregular Heart Beat	Yes	No	Heart Surgery / Angioplasty	Yes	No
Atrial Fibrillation	Yes	No	Coronary Artery Disease	Yes	No
			Other:	Yes	No

Gastrointestinal:

Motion Sickness	Yes	No	Peptic Ulcers	Yes	No
Diarrhea	Yes	No	Liver Disease / Cirrhosis / Jaundice	Yes	No
Gallstones	Yes	No	Irritable Bowel Syndrome	Yes	No
Reflux / Heartburn/ Hiatal Hernia	Yes	No	Gastroparesis	Yes	No
			Other:	Yes	No

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Medical History

Gyn/Breast:

Breast Cancer/ Mastectomy	Yes	No	Uterine Cancer	Yes	No
Breast Disease	Yes	No	Prolapse	Yes	No
Endometriosis	Yes	No	Other: _____	Yes	No

Age of first period _____ Date of last period _____ Age of menopause _____
Number of pregnancies _____ Number of births _____ Breast Feeding _____

Last Mammogram _____ ☐ Reported as normal by patient ☐ Report interpreted as normal

Musculoskeletal:

Artificial join / prosthesis	Yes	No	Osteoporosis	Yes	No
Multiple Sclerosis	Yes	No	Other: _____	Yes	No

Skin:

Cancer	Yes	No	Eczema	Yes	No
Psoriasis	Yes	No	Other: _____	Yes	No
Do you go to a tanning bed?	Yes	No	Do you use sunblock?	Yes	No

How do you tan? [ ] Burn [ ] Usually Burn [ ] Sometimes Burn [ ] Rarely Burn [ ] Never Burn

Hair:

Hair thinning	Yes	No
Baldness	Yes	No
Hair Shedding	Yes	No

Psychiatric:

Depression / Anxiety	Yes	No	Schizophrenia	Yes	No
ADHD / Bi-Polar	Yes	No	Dementia	Yes	No
Eating Disorder	Yes	No	Other:	Yes	No

Endocrine:

Diabetes	Yes	No	Thyroid Disease	Yes	No
(if yes, insulin dependent?)	Yes	No	Hypoglycemia	Yes	No
			Other:	Yes	No

Renal/Genitourinary:

Kidney Stones	Yes	No	Prostate Disease	Yes	No
Kidney Disease	Yes	No	Frequent Urinary Tract Infections	Yes	No
Kidney Failure	Yes	No	Other:	Yes	No

Vascular:

Aneurysm	Yes	No	Vasculitis	Yes	No
Peripheral Vascular Disease/ poor circulation	Yes	No	Varicose Veins	Yes	No
			Other: _____	Yes	No

Rheumatology:

Rheumatoid Arthritis	Yes	No	Raynaud's Disease	Yes	No
Osteoarthritis	Yes	No	Fibromyalgia	Yes	No
Lupus / Scleroderma	Yes	No	Other:	Yes	No

Hematology / Infectious Disease:

Anemia	Yes	No	Sexually Transmitted Disease	Yes	No
Bleeding Tendencies	Yes	No	Hepatitis	Yes	No
Hemophilia	Yes	No	HIV / AIDS	Yes	No
Sickle Cell	Yes	No	Blood Transfusions	Yes	No
Leukemia / Lymphoma	Yes	No	Other: _____	Yes	No

Cancer/ Malignancy:

Location:			Radiation	Yes	No
Chemotherapy	Yes	NO	Date finished treatment: _____		

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Medical History

Past Surgical History: (please list name of procedure and date)

1._____ 2._____

3._____ 4._____

5._____ 6._____

Medications: (Please list current medications, including vitamins and herbal supplements, and dosages.)

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

In the past 6 months have you or are you taking any medications for weight loss? This includes Semaglutides (Wegovy, Ozempic, Rybelsus) Tirzepatides (Mounjaro, Zepbound) and Phentermines (Adipex-P, Contrave) ? YES NO

If yes- Which medication? _____ Ordering Provider: _____

Last Dose? _____

Drug/Food Allergies: YES / NO **List:**_____

_____

Reactions:_____

Do you have an allergy to Latex? YES NO
Do you have an allergy to Codeine? YES NO
Have you ever been on Accutane? YES NO
If yes, when: _____

Social History:

1. Occupation:_____
2. Do you drink alcohol?
   How much:_____How often?_____
3. Single/ Married/Separated/Divorced/Widowed (circle one)
4. Do you use recreational drugs, including medical marijuana? _____
   Yes No _____
5. Have you ever used tobacco? Yes No Type:_____If yes, # of packs per day?:_____for # of years?:____
   If you quit using tobacco, when?_____
6. Do you vape? Yes No Type:_____If yes, # of times per day?:_____for # of years?:____

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Medical History

Family History: Please list any family medical history/problems.

	Age	Diseases	Cause of Death
Father			
Mother			
Sibling			

Do you have a family history of Malignant Hyperthermia? Yes No

Do you have a family history of Sudden Cardiac Death? Yes No

ACKNOWLEDGEMENT:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Bellissimo Plastic Surgery of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Patient Signature: _____ **Date:** _____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____, understand that as part of my health care, Bellissimo Plastic Surgery & Medi Spa originates and maintains paper and/or electronic 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 health 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; and
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Policies that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Bellissimo Plastic Surgery & Medi Spa is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me a permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Bellissimo Plastic Surgery & Medi Spa reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Bellissimo Plastic Surgery & Medi Spa change their notice, they will give a revised notice to the patient upon the next office visit.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

Bellissimo
PLASTIC SURGERY & MEDI SPA

Due to changes in healthcare and technology, Bellissimo Plastic Surgery & Medi Spa has the ability to provide certain information via email and/or text messaging. If you wish to receive messages from us in this way, please fill out the information below. Bellissimo Plastic Surgery & Medi Spa does not share the names, email addresses, or telephone numbers of our patients with any other company.

I authorize Bellissimo Plastic Surgery & Medi Spa to contact me via email at:

_____

I consent to receiving text messages/appointment reminders from Bellissimo Plastic Surgery & Medi Spa at:

(_____)_____

I understand that text messages are transmitted over a public network onto a personal telephone and as such may not be secure. For this reason, the practice will not transmit PHI via text message. Please call the office directly to discuss issues related to your care.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____ _____

Patient Signature (or personal representative) Date

FOR OFFICE USE ONLY

[ ] Consent received by_____on_____ [ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____

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PATIENT CONSENT AND RELEASE OF MEDICAL PHOTOGRAPHY

I have consented to the taking of photography, audio/visual recordings or other images of me by Bellissimo Plastic Surgery & Medi Spa, which will become part of my medical record. I understand that my photographs, video, digital and other images may be recorded to document and assist with my care. I acknowledge that the Practice will own these images, but that I will be allowed access to view them or obtain copies of them as part of my medical record. I also understand that the images that identify me can be released and/or used outside the Practice only upon written authorization from me.

I hereby authorize Bellissimo Plastic Surgery, LLC ("Bellissimo") to use pre-operative, intra-operative and post-operative photography for publication, or republication, in any print, visual or broadcast media, including, but not limited to, showing these images on public or commercial television, electronic digital networks, the Internet, and web sites or web pages, for purposes of medical education, patient education, viewing by perspective patients, lay publications, publications for marketing and/or advertising, newspaper and magazine articles, or during lectures to medical or lay groups.

Neither I, nor any member of my family, will be identified by name in any publication. Although measures will be taken to reduce or eliminate identifying features, the possibility remains that someone may recognize me.

I discharge all rights that I may have in the photographs and I release and discharge, Bellissimo, its assigns and licenses, from any claim that I may have relating to such use and publication, including any claim for payment in connection with distribution or publication of the photographs.

I understand that if I allow my images be used in publications, I have the right to revoke this consent up until the time the images are accepted for publication. Once the images have been published, I may not revoke my consent. Anonymity cannot be guaranteed in publications.

I have been provided the opportunity to ask questions concerning medical photography and understand that refusal to consent will not affect my medical care. If the patient is under 18 years of age, I verify that I am the parent or guardian of patient and that I will sign for the patient.

I certify that I have read the above authorization and release and fully understand its terms, intending to be legally bound hereby.

Initials

_____I agree and authorize the use of my photos.

_____ I **DO NOT** authorize the use of my photos.

Patient Name Printed: _____

Signature of Patient (Parent/Guardian): _____

Date: _____

Witness: _____ Date: _____

Notice of Privacy

Practices Summary

Our practice has a long- standing commitment to confidentiality and protecting the privacy of patient information, which includes any information related to your health, treatment or payment for your treatment that can identify you. Our privacy practices are in accordance with applicable federal and state laws.

New federal legislation requires that we have a "Notice of Privacy Practices". A copy of the notice for our practice is available at our front office. This notice explains how we protect your privacy, as well as your legal rights regarding your medical information. This is a brief summary of the content of the "Notice of Privacy Practices." It is not a complete listing of how we use and share your health information.

We may use and disclose your information without your consent:

- To provide treatment to you
- To coordinate your care with other providers
- To conduct standard health care operations business functions
- To bill and receive payment for the services we provide to you, including billing your insurance company or other party responsible for your bills
- To comply with pertinent government agency reporting requirements
- To meet other special reporting requirements as described in the Notice

(Note that information related to behavioral health, drug and alcohol services and AIDS/ HIV are protected by additional state laws.)

We can share your health information with family and /or friends who you agree can have this information. You can give verbal permission for these disclosures.

All other use of your health information will be made only with your specific written permission, or authorization.

You have the following legal rights regarding your health information:

- Right to see your medical record
- Right to have a copy of your medical record (there may be a charge for this)
- Right to ask for a list of who has seen your health information for any reason other than treatment, payment or other health care operations
- Right to ask for more restrictions on the use of your health information. (We are not required to agree to your request.)
- Right to ask for special confidential communication from our practice. (We are not required to agree to unreasonable requests.)
- Right to ask for a change to be made to your medical record
- Right to a copy of our "Notice of Privacy Practices"
- Right to file a complaint if you feel your privacy was violated

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Acknowledgement of Receipt of Notice of Privacy Practices

Bellissimo Plastic Surgery & Medi Spa has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information. You may review our current notice prior to signing this acknowledgement.

I acknowledged that I have received the Notice of Privacy Practice for Bellissimo Plastic Surgery & Medi Spa.

_____ _____

Name of Patient (Printed or Typed) DOB

_____ _____

Signature of patient (or personal representative) Date

(Personal Representative is required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Personal Representative to Patient

Please specify to whom other than yourself, we may release your protected health information (PHI) including lab or test results and diagnosis:

Name: _____

Name: _____

I,_____authorize Bellissimo Plastic Surgery & Medi Spa

Signature of patient (or personal representative)

to contact me and/or named authorized person(s) and to convey PHI and assume responsibility to notify Bellissimo Plastic Surgery & Medi Spa whenever this information changes.

FOR OFFICE USE ONLY

I have provided the above-named patient or patient representative with the Notice of Privacy Practices for Bellissimo Plastic Surgery & Medi Spa.

_____ _____

Employee Signature Date

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BELLISSIMO PLASTIC SURGERY & MEDI SPA
Breast Reduction Questionnaire

Name_____ Date: _____ Date of Birth: _____

Height _____ Weight _____ Bra Size _____ Primary Doctor _____

Number of births_____ Breast Feed? Y / N Planning More Children? Y / N

Last Mammogram Date_____ Result _____

Previous Breast Surgery _____

Do you have any of the following: (Please check all that apply):

_____Breast pain
_____Shoulder pain
_____Neck pain
_____Unspecified Back pain
_____Lower Back pain
_____Intertrigo
_____Poor Posture
_____Interferes with Daily Activity
_____Finger or Hand numbness
_____Bra strap indent/shoulder grooving
_____Ptosis Breasts
_____Nipple Discharge
_____Fibrocystic breasts
_____Breast Masses
_____Rash beneath breasts

Length of time symptoms experienced _____
Please estimate the number of physician visits you sought over the past 5 years regarding these symptoms_____.
Please list the physicians by name and specialty from which you have sought treatment for these symptoms over the past 5 years:

Name	Specialty
_____	_____
_____	_____

Please list prescription medications taken for these symptoms over the past 5 years:

_____

Please list over the counter (non-prescription) medications used for these symptoms and the frequency of use over the past 5 years:

_____

Please check any of the medical or non-medical treatments or services below that you have used for your symptoms:

_____Physical Therapy (Duration of treatment:_____)
_____Chiropractic (Duration of treatment:_____)
_____Massage or ultrasonic treatment
_____Acupuncture
_____Support Bras
_____Spinal x-rays (neck or back)
_____Cold/ice
_____Electric Stimulation
_____Posture Training
_____Strengthening Exercises
_____Medications

Please list any other treatments or services used _____

_____

_____ _____
Signature **Date**

Revised: 7/1/15