Craig Staebel M.D. P.A.

Plastic and Reconstructive Surgery

Name:_____ Age:_____ Date: _____

REASON FOR CONSULTATION :_____

Due to an injury? Y N On the job injury? Y N Auto Accident? Y N Date of injury/accident: _____

PAST MEDICAL HISTORY: (Have you ever had any of the following medical conditions?)

High blood pressure	Y N	Stomach ulcer or gastritis	Y N
Heart attack or congestive heart failure	Y N	Hepatitis or other liver disorder	Y N
Heart murmur or heart valve disorder	Y N	Kidney disease or failure	Y N
Asthma, bronchitis or COPD	Y N	History of blood clots in the veins of your legs	Y N
Stroke or paralysis	Y N	Anemia or any other blood disorder	Y N
Diabetes or thyroid disorder	Y N	Transfusion of blood or blood products	Y N
Autoimmune disease	Y N	Glaucoma or other eye disorder	Y N
Arthritis or degenerative joint disease	Y N	Seizure disorder	Y N
Cancer (What type? _____	Y N	History of any psychiatric disorder	Y N

Any other medical problems (Be specific): _____

PAST SURGICAL HISTORY: (List all previous operations by date and any associated problems with the surgery or anesthetic)

Surgery	*Date*	*Problems with surgery or anesthetic*

MEDICATIONS: (Prescriptions, over-the-counter and herbal)

Medication	*Dose*

ALLERGIES (Reaction to any medication, drug or anesthetic)

Medication	*Reaction*

SOCIAL HISTORY:

Marital status: S *M D W* Number of children: _____ Children at home: _____ Hobbies: _____

Do you use tobacco? *Never In the past Occasionally Regularly* Amount/day:_____ Number of years: _____

Do you drink alcohol? *Never In the past Occasionally Regularly* Amount/day: _____ Number of years: _____

Recreational Drugs? *Never Occasionally Regularly* _____

FAMILY HISTORY: (Any history of the following conditions in a blood relative? Which family members?)

High blood pressure	Y N	_____	Stroke	Y N	_____
Diabetes	Y N	_____	Bleed Disorder	Y N	_____
Cancer (type)	Y N	_____	Blood Clots/DVT	Y N	_____
Heart Disease	Y N	_____			

REVIEW OF SYSTEMS: (Have you recently experienced or do you currently have any of the following symptoms?)

Recent weight loss or easy fatigability	Y N	Pain or burning when you urinate	Y N
Fever, chills or night sweats	Y N	Pain in your extremities or major joints	Y N
Change in vision or temporary loss of vision	Y N	Slow wound healing or excessive scaring	Y N
Excessive tearing or excessively dry eyes	Y N	Change in size **or** color of a mole or other growth	Y N
Irregular heart rate or palpitations	Y N	New lumps or discomfort in your breast	Y N
Tightness, pressure or pain in your chest	Y N	Dizziness, light-~headedness or faintness	Y N
Swelling of your feet or ankles	Y N	Weakness in any extremity	Y N
A recent cold, flu or pneumonia	Y N	Any unusual stress in your life at this time	Y N
Wheezing or shortness of breath	Y N	Any chance that you may be pregnant	Y N
Heartburn or reflux	Y N	Excessive or prolonged bleeding when cut	Y N
Frequent loose stools or constipation	Y N	Any known deficiency of your immune system	Y N
Blood in your stool or urine	Y N	Allergy or reaction to Latex	Y N

FOR OFFICE USE ONLY Ht ___' ___" Wt _____ BP ____/_____ P _____ R _____

Reviewer's Init: _____

Craig Staebel, M.D. P.A.

Cosmetic and Reconstructive Surgery

PERSONAL DATA:

Full Name:_____ **Name you like to be called:**_____

Date of Birth:_____ **Age:**_____ **Sex:**_____ **Social Security Number:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

E-Mail Address:_____

I authorize Georgetown Plastic Surgery to contact me using the provided email address. _____
Signature

Marital Status: S M D W **Spouse's Name:**_____

EMERGENCY CONTACT:

Name:_____ **Relation to Patient:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

HOW DID YOU HEAR ABOUT US?

Physician Referral:_____ **Patient Referral:**_____
(Name of Physician) **(Name of Patient)**

Website:___ **Looking Your Best.com:**___ **Phone Book:**___ **Online:**___ **Other:**_____

Name of Primary Care Physician:_____

Areas of Interest: (mark all that apply)

Facial Procedures

- ❒ Blepharoplasty (Eyelid Lift)
- ❒ Botox
- ❒ Brow or Forehead Lift
- ❒Earlobe Repair
- ❒Facial Liposuction (Neck, Jowls)
- ❒ Face or Neck Lift
- ❒ Lip Enhancement
- ❒ Otoplasty (Ear Pinning)
- ❒ Rhinoplasty (Nose Reshaping)
- ❒ Skin Resurfacing (Laser, Peel, Etc.)
- ❒ Wrinkle Fillers (Injections)

Breast Procedures

- ❒ Breast Augmentation
- ❒ Breast Reconstruction
- ❒ Breast Reduction
- ❒ Mastopexy (Breast Lift)
- ❒ Nipple Reduction or Inversion

Body Procedures

- ❒ Abdominoplasty (Tummy Tuck)
- ❒ Brachioplasty (Arm Lift)
- ❒ Full Body Lift
- ❒Liposuction (Thighs, Abdomen, Etc.)
- ❒ Thigh or Buttock Lift

Other Procedures

- ❒ Skin Care
- ❒ Telangectasia (spider veins)
- ❒ Laser Hair Removal
- ❒ Leg Veins
- ❒ Lesions / Moles
- ❒ Scar Revision

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Office: 512-686-1650 Fax: 512-686-1652

Craig Staebel M.D P.A.
Plastic and Reconstructive Surgery
Consent for Purposes of Treatment, Payment and Healthcare Operations

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I consent to the use or disclosure of my protected health information by Craig Staebel M.D. P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Craig Staebel M.D. P.A. I understand that diagnosis or treatment of me by Dr. Craig Staebel may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Craig Staebel M.D. is not required to agree to the restrictions that I may request. However, if Craig Staebel M.D. PA agrees to a restriction that I request, the restriction is binding on Craig Staebel M.D., P.A. and Dr. Craig Staebel.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Craig Staebel or Craig Staebel M.D., PA has taken action in reliance on this consent.

I understand that photographs may be taken of me during the course of my treatment and are part of the medical record. I understand that my photos may be used in publications, advertising, website placement, patient instructional situations, and for case collection purposes as required for board certification and maintenance of certification. I may revoke with consent at any time, allowing reasonable time to remove any photos currently in use.

In providing an email address, I consent to being placed on the Practice's emailing list and to receive periodic promotional materials. I understand I may remove myself from this list at any time.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Craig Staebel M.D., P.A.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Craig Staebel M.D., P.A. This Notice of Privacy Practices also describes my rights and the Craig Staebel M.D., P.A.'s duties with respect to my protected health information.

Craig Staebel M.D., P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Craig Staebel M.D., P.A.'s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Print Name of Patient or Personal Representative | Description of Personal Representative's Authority