Mark D. Epstein, MD, FACS
PLASTIC & AESTHETIC SURGERY

Patient Information

Today's Date: _____

First Name:_____M.I._____ Last Name:_____

Social Security Number: _____ DOB: _____Age:_____

Address: _____

City:_____State:_____ Zip:_____

Home Telephone: _____ Work Phone: _____

Cell Phone: _____ Occupation: _____

Preferred Phone (Circle One): Home Cell Work

Patients Email Address: _____

RACE
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other

ETHNICITY
- ☐ Hispanic
- ☐ Non-Hispanic

GENDER
- ☐ Male
- ☐ Female

MARITAL STATUS
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widow
- ☐ Other

REFERRAL
- ☐ Internet
- ☐ Our website
- ☐ Friend/Relative
- ☐ Other

Explain Name/Other: _____

Preferred Language:_____Emergency Contact & Phone:_____

Primary Physician:_____Telephone: _____

Address:_____

City: _____ State:_____ Zip:_____

Pharmacy: _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip: _____

Acknowledgement of Receipt of Information

I was provided with the Disclosure of the Providers of Care in this organization, a copy of the Patient Bill of Rights and Responsibilities; information regarding the grievance process and information regarding the infection control processes of this organization.

Mark D. Epstein, M.D., F.A.C.S. reserves the right to modify the above without notice.

Please check one of the boxes below:

I understand this information ☐ OR I do not understand this information ☐

Name of Patient	Signature of Patient	Date

Signature of Patient Representative	Relationship	Date

Witness	Date

Tel. 631.689.1100 Fax 631.751.0103
200 Motor Parkway | Suite B-12 | Hauppauge, New York 11788
www.epsteinplasticsurgery.com

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Authorization for Examination

I,_____, represent to Mark D. Epstein, M.D. and his staff that I am at least 18 (eighteen) years if age, or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by Dr. Epstein and such assistant or staff that may be assigned by him.

I understand that Dr. Epstein cannot bill my insurance carrier, as cosmetic surgery is a non-covered medical expense. However, if my procedure is determined to be non-cosmetic, I authorize the release of any medical information for processing insurance claims on my behalf. I authorize payment of medical benefits directly to Dr. Epstein for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of litigation arising from treatment, I agree to submit the case to arbitration. I understand that photography is necessary part of the planning and evaluation of cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of Dr. Epstein and under such conditions as approved by him. These photographs are used solely for documentation purposes and will be kept confidential, unless a specific separate release is signed by me directing otherwise.

Patient Signature Patient Name Date

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Patient Contact Questionnaire and HIPAA Acknowledgement

Patient Name:_____Date:_____

You may be contacted by this office to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. May we:

Contact you at home?	**YES**	**NO**	Telephone #_____
Leave voicemail?	**YES**	**NO**	Telephone #_____
Contact you at work?	**YES**	**NO**	Telephone #_____
Leave voicemail at work?	**YES**	**NO**	Telephone #_____
Contact you via cell phone?	**YES**	**NO**	Telephone #_____
Contact you via email?	**YES**	**NO**	Email Address _____
Contact you via text?	**YES**	**NO**	Telephone #: _____

Can a message be left with our office name and what the call is in reference to? **YES** **NO**

Is there anyone we can leave a message with? **YES** **NO**

If yes, please list first and last name: _____

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm, or change appointments only. **YES** **NO**

If yes, please list first and last name: _____

Mark D. Epstein, M.D., F.A.C.S. has provided me with a copy of the privacy policy for this practice which describes my right as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my right and receive answers to my satisfaction.

Mark D. Epstein, M.D., F.A.C.S. reserves the right to modify the privacy practices outlined in this notice.

_____

Name of Patient | Signature of Patient

_____

Signature of Patient Representative | Relationship of Patient Rep. to Patient

_____

Witness

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Patient Acknowledgement
Receipt of Privacy Notice

I _____hereby affirm that I have received a copy of the Notice of Privacy Practices from _____. Under federal law 104-191, also known as HIPPA, I am entitled to receive copy of this Notice from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the Notice and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the Notice of Privacy Practices from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name:_____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority (if applicable)

FOR OFFICE USE ONLY

RECEIVED BY:_____

DATE RECEIVED: _____ TIME RECEIVED:_____

PATIENT DECLINED:_____

STAFF SIGNATURE:_____

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Medical History

Patient Name: _____ Date Of Birth:_____

Who referred you to this office: _____

For what reason are you here today: _____

_____

Have you seen another physician about this problem? Yes_____ No_____

If yes, who? _____

Medications take routinely, both prescription and non-prescription, including aspirin, birth control pills, etc._____

_____

Have you ever used diet pills? Yes_____ No_____

Herbal supplements taken: _____

Allergies: Drug Allergies: _____

Other Allergies: _____

Have you ever used (circle): Cocaine Marijuana Illegal Drugs?

Have you ever had a bad reaction to any medications? Yes_____ No_____

If yes, please list the medications and reactions: _____

_____

Have you or anyone in your family ever had a reaction to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fever? Yes_____ No_____

Have you ever been told that you should take an antibiotic before undergoing dental or surgical procedures?

Yes_____ No_____

Do you have (circle): Loose or chipped teeth Caps Dentures Contact Lenses None

Do you have any prosthetic (artificial) devices implanted (i.e. heart valve, hip, knee)?

Yes_____ No_____

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Medical History

Approximate Height: _____ Approximate Weight: _____

Have you ever had, or been treated for: (please check YES or NO, elaborate as necessary)?

YES NO

{} {} Unexplained weight loss or gain
{} {} Emotional problems, depression or other psychiatric history
{} {} Migraines
{} {} Breast disorder
{} {} Skin disorders (including cancer)
{} {} Tumors, benign or malignant (cancer)
{} {} Asthma, breathing problems or shortness of breath
{} {} Back or neck pain
{} {} Arthritis
{} {} Disorders of muscle, bones or joints
{} {} Low blood count (anemia)
{} {} Leukemia
{} {} Problems with bleeding, difficulty clotting (Hemophilia, Von Willebrand's)
{} {} Blood clots in legs or lungs
{} {} Neurologic disease or epilepsy
{} {} Stroke
{} {} Diabetes
{} {} Prostate disease
{} {} Urinary tract or kidney disease
{} {} Uterine/cervical disorders
{} {} Thyroid disease
{} {} Endocrine (hormone) disorders
{} {} Congenital heart disease
{} {} Heart attack, chest pain
{} {} High blood pressure
{} {} Gastrointestinal problems, colitis, ulcer
{} {} Other medical problems

_____
_____

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Have you ever seen a cardiologist? Yes_____ No_____ Date of last EKG:_____

Do you have a pacemaker? Yes_____ No_____

Have you ever been told that you should not or cannot donate blood? (If Yes, Why?) _____

Do you smoke? Yes_____ No_____ # packs per day: _____

Do you drink alcohol? Yes_____ No_____ # of drinks per day: _____

Are you pregnant, trying to get pregnant or breast feeding? Yes_____ No_____

Has anyone in your family been diagnosed with Breast Cancer? (If Yes, Who?) _____

Surgical History

List previous operations, including cosmetic surgery and serious injuries (include dates):

_____

_____

_____

Family History

Mother: Alive_____ Deceased_____ Age/Cause of death_____

Father: Alive_____ Deceased_____ Age/Cause of death_____

Siblings: Alive_____ Deceased_____ Age/Cause of death_____

Forms Compiled by: _____Date:_____
(Patient's Signature)

Doctor's Signature: _____Date:_____

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COMPLIMENTARY SKIN CONSULTATION

Name: _____ Date: _____

Phone Number: _____ Date of Birth: _____

Are you happy with the condition of your skin? YES, or N0
Are you currently using any skincare products? YES or NO?
if yes, list products below and how long you are using them:

What areas of concern do you have regarding your skin: *Circle any that apply to you*.

Uneven skin tone Sun damage Wrinkles/fine lines Dehydrated skin Sun spot/ brown spot

Dark circles around eyes cracked/chapped lips Dull/dry skin Redness Breakouts

What SPF do you use? How often/ when?

Are you interested in discussing Botox or fillers with a nurse? YES NO
Have you ever had Botox, Juvederm, Vollure, Volbella, Voluma or Bellafill? YES NO
Are you interested in Micro Needling and PRP for facial rejuvenating? YES NO
Are you interested in PRP for hair loss? YES NO
Is double chin a concern of yours? YES NO

Men Only: Do you have irritation from shaving: YES NO,
if yes, are you interested in a skin care product that will help with the irritation? YES NO

Female Only: Are you interested in Vaginal Rejuvenation? YES NO

Are you interested in attending any of our special events? YES NO
If so please provide your email address below.

_____

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GENERAL DIRECTIONS TO OUR OFFICE:

From west, take LIE to Exit 55, Motor Parkway. Head north on Motor Parkway. We are on the corner of Motor Parkway and Adams Avenue.
From east, take LIE to exit 55, Motor Parkway. Make a right onto Motor Parkway, head north. We are on the corner of Motor Parkway and Adams Avenue.

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