Today's Date:

DIANA PONSKY
MD FACS
FACIAL • PLASTIC • SURGERY

3700 Park East Dr., STE 160
Beachwood, OH 44122
(216) 508 4055
www.DrDianaPonsky.com

ADULT PATIENT QUESTIONNAIRE

Name: (Last, First) _____ (M.I.) _____

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

Height: _____ Weight: _____ D.O.B. _____ Age: _____ Sex: _____

Cell Phone: _____ Home Phone: _____

Primary Care Physician: _____ Reason for Visit: _____

MARITAL STATUS: (CIRCLE) MARRIED SINGLE DIVORCED SEPARATED WIDOWED enter here if filling out online

SSN: _____ Email: _____

Employer Name: _____ Work Phone: _____

EMERGENCY CONTACT

NAME:_____

PHONE:_____

RELATIONSHIP:_____

IF UNDER 18: WHO IS RESPONSIBLE PARTY

NAME:_____

PHONE:_____

RELATIONSHIP:_____DOB_____

HOW DID YOU HEAR ABOUT US?

☐ **PHYSICIAN** ☐ **FRIEND** ☐ **GOOGLE / INTERNET SEARCH** ☐ **OTHER**

Whom may we thank for the referral:_____

PHARMACY

Name :_____ City :_____

State: _____ Zip Code: _____ Phone: (optional)_____

INSURANCE INFORMATION

Primary Insurance:_____

Policy Number :_____Group Number:_____

Policy Holder Name: _____ Policy Holder DOB: _____

Secondary Insurance:_____

Policy Number:_____

Policy Holder Name: _____ Policy Holder DOB: _____

-TURN OVER-

FAMILY HISTORY

Family Member	Age	Living?	Cause of Death	Chronic Health Problem
		Yes		
		Yes		
		Yes		
		Yes		

Have you ever had surgery? Yes

Procedures and approximate dates:

Have you or a family member had an unusual reaction to anesthesia? Yes

Please check below any CURRENT or PAST medical conditions:

- ☐ Acid Reflux Disease
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorders:_____
- ☐ Bladder Problems
- ☐ Bleeding Problems
- ☐ Bronchitis
- ☐ Cancer:_____
- ☐ Cataracts
- ☐ Chest Pain
- ☐ COPD
- ☐ Diabetes
- ☐ Coronary Heart Disease
- ☐ Depression
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Hiatal Hernia
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Lung Problems
- ☐ Kidney Problems
- ☐ Prostate Problems
- ☐ Psychiatric Problems
- ☐ Seizures
- ☐ Sickle Cell
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other:_____

Are you currently pregnant or breastfeeding? No

Please provide a list of your medications, including over the counter medicine, vitamins, and herbs

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE

Are you allergic to any medications? No

Please list what kind and describe what happens:

List any other allergies:

Do you smoke? No
Former smoker: No
Cigarettes / Pipe / Cigars / Marijuana / Other

If cigarettes: How many per day? _____
How long did you smoke? _____
If you quit, when?_____

Have you regularly used snuff or chewing tobacco? No

Do you drink? No

Beer / Wine / Hard liquor
How many drinks _____(per week / day)
If you quit, when?_____

Doctor's / Nurse's Notes:

BP:

P:

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General Consent

Authorization for Treatment

Patient/Patient's legal representative agree to permit authorized personnel of PONSKY FACIAL PLASTIC SURGERY, LLC to perform such diagnostic and therapeutic procedures that my treating physician(s) deem necessary for care. By signing below, I agree to permit x-rays, laboratory tests, photographs for treatment purposes, routine medical treatment (for example, medications, injections, drawing blood for tests, emergency procedures as necessary and hospital services performed at the request of the physicians arising in my care. I understand that, except in an emergency, any further treatment or procedures will be performed only after I have been informed of the benefits, material risks, and complications associated with such treatment or procedures and I have been given my consent.

Authorization to Release Information

The undersigned hereby permits PONSKY FACIAL PLASTIC SURGERY, LLC and/or their authorized personnel to access and/or release all or any part of the patient information to the appropriate healthcare insurer(s), employers for work-related injuries, third party payer(s), and/or PONSKY FACIAL PLASTIC SURGERY, LLC agent(s), attorney(s) for purposes including treatment of the patient, billing (or collecting payment) for services and healthcare operations.

Record Retention Policy

PONSKY FACIAL PLASTIC SURGERY, LLC retains patient medical records in accordance with applicable law and pursuant to its record retention policies.

Computer Data

I understand that my medical records will be accessible to authorized PONSKY FACIAL PLASTIC SURGERY, LLC personnel through computers and that the Company will comply with certain safeguards established by federal state and local law as well as PONSKY FACIAL PLASTIC SURGERY, LLC policy.

Certification

I certify that to the best of my knowledge and belief the information provided is complete and correct. I understand that this consent is subject to revocation by me at any time except if the person or entity authorized to make a disclosure has already acted in reliance on this form. Otherwise, subject to applicable law, this consent will expire at the same time PONSKY FACIAL PLASTIC SURGERY, LLC record retention period for this document expires.

Patient Personal Property/Payment for Non-Reimburseable Items

I understand that PONSKY FACIAL PLASTIC SURGERY, LLC is not responsible for loss or damage to money and valuables left unattended.

I AM THE PATIENT OR AUTHORIZED TO SIGN THIS DOCUMENT. I HAVE READ ALL THE ABOVE AND UNDERSTAND ITS TERMS.

_____
Printed Patient Name

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Legal Representative **Relationship**

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Medical Information Release Form
HIPAA Release Form

Name:_____**D.O.B.**_____

Date:_____

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

☐ SPOUSE: _____

☐ CHILD(REN):_____

☐ OTHER:_____

☐ PONSKY FACIAL PLASTIC SURGERY, LLC

☐ **Information is NOT to be released to anyone.**

The Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:

☐ My home: _____

☐ My work:_____

☐ My cell:_____

If unable to reach me:

☐ Leave a detailed message
☐ Leave message to return call
☐ Other:_____

☐ **I would NOT like to receive email notifications, promotions, and reminders.**

_____ _____
Signature **Date**

_____ _____
Witness **Date**

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Photo Release Consent

I understand that photographs may be taken during my visit. I accept that I may be recognized from my likeness or case history. Nevertheless, I authorize my plastic surgeon to use my photographs, videotapes, and case information in the settings that I have checked:

☐ **For office and surgical use only**

☐ Lectures and multi-media presentations for an audience of medical professionals

☐ Medical, surgical, and scientific journal articles and publications

☐ My surgeon's file of pre- and post-operative patient photographs available to prospective patients for viewing in the office

☐ For use by the American Academy of Facial Plastic and Reconstructive Surgery

☐ **For *all* of the below**

☐ My surgeon's personal website or webpage

☐ Social media, including but not exclusive to Facebook and Instagram

☐ Newspaper and magazine articles in which my surgeon participates

☐ Television programs in which my surgeon participates

☐ Lectures and multi-media presentations given by my surgeon to the general public

Patient Signature _____ Date_____

Print Name _____

Witness Signature _____ Date_____

Print Name _____

The consent provided in this document shall be valid immediately and until such time as a patient affirmatively withdraws, in a writing addressed to PONSKY FACIAL PLASTIC SURGERY, LLC, from the consent provided herein. Such withdrawal shall be effective upon its receipt by PONSKY FACIAL PLASTIC SURGERY, LLC.

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Private Pay Acknowledgement For Cosmetic Procedures

NOTE: You have a choice to make about receiving elective health care items or services.

Diana Ponsky Facial Plastic Surgery collects payment at the time of service unless other financial arrangements are made.

Insurance Coverage: It has been our experience that the majority of cosmetic procedures are not covered by insurance plans. However, benefits paid by insurance companies do vary, therefore, you should check with your carrier regarding coverage for cosmetic surgery.

By signing below, **you acknowledge and accept financial responsibility for any items or services provided by Diana C. Ponsky, MD, FACS.** The reason may be that your doctor is not in network with your insurance company, certain services are not covered by your insurance company, or you are choosing to not use your insurance even though your selected clinician is participating in your insurance plan.

For more information about specific plan coverage, you will need to consult with your insurance carrier or your benefits booklet.

_____ _____

Patient Signature/ Patient Representative **Date**