Lake Medical Spa

Osage Beach, Waynesville, Rolla and Columbia

573-348-4863

Date:_____ Main Phone:_____ Secondary Phone:_____

First Name: _____ Last Name: _____ M.I. _____

Address: _____ City:_____

State: _____ Zip:_____ Email:_____

Social Security #_____ Date of Birth: _____ Sex: Male Female

Please Circle: Married Single Divorced Widowed Separated Domestic Partner

Primary Doctor's Name:_____ Referring Doctor:_____

Preferred Pharmacy: _____ Phone Number: _____

Whom may we thank for referring you? _____

In case of an emergency, who's notified? _____ Phone #_____

Patient Employer/School_____ Phone #_____

Employer/school address_____

Osage Valley Plastic Surgery has my permission to leave information on my answering machine, such as, test results, billing information, medical information, and appointment information.

☐YES ☐NO If we are unable to reach you, may we leave your information with someone specific?

Name: _____ Number: _____ Relationship: _____

PHOTO CONSENT

As part of my consultation, I understand that photographs may be taken to record my pre-operative and/or post-operative status and will become part of my medical records.

_____ I give my authorization for my before and after photographs to be shown to patients who are contemplating a similar procedure. Every attempt will be made to conceal my identity: however, I understand that photographs of facial procedures may not be able to conceal my identity.

_____ I **DO NOT** wish for my photographs to be shown to patients who are contemplating a similar procedure.

Patient Signature: _____

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Name:_____ Date:_____

Have you had or have:

- ❏ Flu shot within the last 2 weeks/ COVID vaccine or booster
- ❏ Dental cleaning or dental work within the last 2 weeks or scheduled within the next 2 weeks
- ❏ Active skin infections
- ❏ Any active bacterial, viral, body or blood infection
- ❏ Active Herpes Simplex or a history of cold sores or fever blisters (contraindicated especially for perioral or lip injections)
- ❏ Undiagnosed or unstable autoimmune disorders
- ❏ Steroid or other immunosuppressive treatments within two weeks of cosmetic injections, e.g., Remicade for RA, Methotrexate, etc
- ❏ Any current or recent (within two weeks) upper respiratory infections or sinus infections
- ❏ Pregnant/and or breast feeding
- ❏ Lidocaine allergies

Please indicate how much and how often for the following:

- ❏ Blood thinners _____
- ❏ Aspirin _____
- ❏ Non-Steroidal (Aleve, Advil, Ibuprofen, Motrin, Celebrex) _____
  _____
- ❏ Herbal Supplements (Gingko, Ginseng, Garlic, Turmeric)
  _____
- ❏ Current antibiotics (include name and dosage)
  _____
- ❏ Multivitamins _____

Do you have plans for:

- ❏ Air travel within 24 hours of dermal filler treatment planned.
- ❏ Future social events planned within the next two weeks.

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Health Questionnaire

Name: _____ Age _____ Sex • F • M

Allergies

Please list all allergies: • none

_____

Are you allergic to: • latex • local anesthetics • antibiotics • adhesive tape • No

Medications

Please list your current medications (or bring a copy to your appointment): • none

_____

_____

Do you take: • aspirin • ibuprofen (Aleve, Advil, etc.) • vitamin E • Fish Oil
Do you take: • Coumadin • Plavix • Xarelto • Eliquis • Any other type of blood thinner?

_____

Family History

Please list any serious conditions that run in your family bloodline:

_____

_____

_____

_____

Medical History

Circle any diagnosed disorders

Pacemaker
Defibrillator
High blood pressure
Heart attack
Stroke or mini-stroke
Deep vein thrombosis Pulmonary embolism
Atrial Fibrillation
Arthritis
Mitral valve prolapse
Heart valve disease
Artificial joint
Other prosthetic
Organ transplant
Diabetes
Thyroid disease
Lymphoma
COPD

Cancer _____
Gout
Back Problems
High Cholesterol
Depression/Anxiety
Cong. Heart Failure
Leukemia
HIV
Hepatitis
Liver disease
Gastric Reflux/Heartburn
Kidney disease
Psychiatric disorder
Keloid scarring
Asthma
Anemia

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Do you have any other health conditions not listed on this form?

_____

_____

Social History

Do you drink alcohol? • Y • N
Do you smoke? • Y • N If yes, for how long? _____ How many cigarettes per day? _____
If no, have you ever? • Y • N How many years ago did you quit? _____

Surgical History

What surgeries have you had?

_____

_____

_____

Height: _____ Weight:_____

Please sign your name and date, indicating that the above information is true and complete to the best of your knowledge:

Signature: _____ Date: _____

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Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in Acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason: