Patient Information Form

Patient's Full Name:_______________________________________ Date of Birth:_____________
Last First MI (MM/DD/YY)

Home Address:____
Street City State Zip

Home Phone:_______________________________Cell Phone:_______________________________

E-Mail Address:____

Sex: F M__________Marital Status: Single Married Widowed Divorced__________

Driver's License #:__________________________Social Security #:__________________________

Patient's Employer:_______________________________________Work Phone:________________

Employer's Address:____

Spouse/Guardian's Employer:____
Name Address City State Zip

In Case of Emergency Contact:__________________________Relationship:_______Phone:__________

Primary Insurance Coverage

Insurance Company:____

Insurance Claim's Address:________________________________Insurance Phone:______________

_Policy #:__________________________________Group #:_____________________________________

If Subscriber is Not the patient, please answer the following:

Subscriber's Name:______________________________Subscriber DOB:______________________

Subscriber's Social Security #:____

Insurance Authorization (check appropriate boxes)

I understand that I am ultimately responsible for all services rendered by Dr. Barone and her staff whether covered by my insurance or not.

I also authorize Dr. Barone and her staff to access my chart for management review.

This is to inform you that Dr. Barone is an investor in the Christus Santa Rosa Surgery Center located on 2833 Babcock Rd., suite100, San Antonio, TX 78229.

I would like to be placed on your mailing list.

____

Patient's Signature Date

Patient History Form

Date:________________
Date of Birth:_______________Age:________

Name:____
Last First M.I.

How did you learn about Dr. Barone?____________________________________

Primary Care Physician:
Name:____
Address:____
Office Telephone:__________________________FAX:__________________

Pharmacy:
Name:______________________________Telephone #:_________________
Address:____

Social History:

Do you Smoke? YES NO
If yes, ______# packs per day______# of years.
If you currently do not smoke when did you stop?___________________

Do you drink Alcohol? YES NO If yes, how much?___________
____

Do you use Recreational Drugs?
Describe____
____

_______________________________ ______________________
Dr. Barone's Signature Date

CONSTANCE M. Barone M.D. F.A.C.S.
CONFIDENCE AND BEAUTY ...SENSIBLY PRICED

List ALL Medications you are taking or have taken within the last month (include aspirin, Motrin and herbal drugs):

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

List All Drug Allergies including Latex, if none write "NKDA":

____
____
____

List ALL Surgical Operations and Hospitalizations you have ever had:

Date//////////////////////////////////////	Date//////////////////////////////////////

______________________ ______________
Dr. Barone's Signature **Date**

Medications to Avoid 3 weeks before Surgery

The following drugs will have an undesirable side affect and will cause abnormal bleeding during your surgery. This is NOT a complete list, so please inform Dr. Barone of All of the medicines you normally take. This includes over the counter drugs and cold medicines. If you need to take a medication for pain prior to surgery, you may take Tylenol.

Advil
Aleve
Alka-Seltzer
Alka_Seltzer Plus
Anacin
Anaprox
Ansaid
Argesic
Arthropan Liquid
Ascodeen-30
Ascriptin
Aspirin (all products)
Bayer Aspirin
BC Powders
Buff-A-Comp
Buffadyne
Formula
Bufferin
Backache
Butalbital
Cama-Inlay Tabs
Cama Arthritis
Caprin Capsules
Celebrex
Cheracol Capsules
Congespirin
Conaretol
Cope
Coricidin
Dolia

Darvon Compound
Daypro
Dristan
Duragesic
Ecotrin
Empirin
Emprazil
Excedrin
Feldene
Four Way Cold Tablets
Fiorinal
Fish Oil
Ginkgo Biloba
Ibuprofen (Motrin)
Measurin
Midol
Monacet with Codeine
Momentum Muscular -
Norgesic
Pabirin Buffered Tablets
Panalgesic
Pain Reliever
Panadynes Analgesic
Persistin
Plavix
Power Drinks
Robaxisal
Sine-Aid
Sine-Off
Sinutab
SX-65 Compound Capsule

Stendin
Stanback Powder/
Max Powder
St. John's Wort
Stero-Darvon with
Aspirin
Supac
Synalgos D.C.
Triaminicin
Triagesic
Ursinus Inlay Tabs
Vanguish
Vioxx
Vitamin E
Vivo Med
Warfarin(Coumadin)
*****All Herbal Meds**

I have read the above list, received a copy and have no further questions.

______________________ ______________
Patient **Date**

______________________ ______________
Dr. Barone's Signature **Date**

Medications to Avoid 3 weeks before Surgery

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Aleve
Alka-Seltzer
Alka_Seltzer Plus
Anacin
Anaprox
Ansaid
Argesic
Arthropan Liquid
Ascodeen-30
Ascriptin
Aspirin (all products)
Bayer Aspirin
BC Powders
Buff-A-Comp
Buffadyne
Formula
Bufferin
Backache
Butalbital
Cama-Inlay Tabs
Cama Arthritis
Caprin Capsules
Celebrex
Cheracol Capsules
Congespirin
Conaretol
Cope
Coricidin
Dolia

Darvon Compound
Daypro
Dristan
Duragesic
Ecotrin
Empirin
Emprazil
Excedrin
Feldene
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Fiorinal
Fish Oil
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Stero-Darvon with
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Supac
Synalgos D.C.
Triaminicin
Triagesic
Ursinus Inlay Tabs
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Vioxx
Vitamin E
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Warfarin(Coumadin)
*****All Herbal Meds**

I have read the above list, received a copy and have no further questions.

**********************Copy to be given to patient*****************************

Review of Systems

Check Yes or No by the current ailment as it applies to YOU. If unsure, place a question mark (?)

General

yes no

____ ____ Weight loss greater than 10 lbs in last year,
If Yes, how much? ___________________________
___ ___ Fever
___ ___Trouble Sleeping
___ ___Poor Appetite

Eyes

___ ___Glasses/Contacts
___ ___Loss or Change of Vision
___ ___Glaucoma or Cateracts
___ ___Eye Surgery such as Lasix
___ ___Dry Eyes
___ ___Frequent use of Eyedrops

Ear, Nose and Throat

___ ___Trouble breathing out of nose
___ ___Nose bleeds
___ ___Hearing Aids/Hearing loss
___ ___Recurrent Ear Infections
___ ___Sore throat/Strep Throat

Cardiovascular

___ ___High Blood Pressure
___ ___Heart Murmur
___ ___Mitral Valve Prolapse
___ ___Irregular heartbeat
___ ___Previous Heart Attack
___ ___Chest Pain
___ ___Deep Vein Thrombosis (DVT)
___ ___History of blood clots

Respiratory

___ ___Shortness of Breath
___ ___Asthma
If Yes, # times a week use an inhaler?______
___ ___History of Tuberculosis
___ ___Chronic Cough
___ ___Emphysema
___ ___COPD (chronic obstructive pulmonary disease)
___ ___History of Apnea
___ ___Pulmonary Embolism (PE)

Gastrointestinal

___ ___Ulcers
___ ___History of Jaundice (yellow skin)
___ ___History Cirrhosis
___ ___History Gallstones

Females ONLY

yes no

___ ___Prior Breast Biopsy
___ ___Breast Lumps
___ ___Bloody Nipple Discharge
___ ___Abnormal Mammogram
Date of Last Mammogram________
___ ___Birth Control?
Method______________________
___ ___Family History Breast Cancer
___ ___Are you pregnant?
___ ___Will you have any more children?

Genitourinary

___ ___Problems Urinating
___ ___Difficulty starting stream
___ ___Painful/Burning/Frequent Urination

Skin

___ ___Skin Cancer
Where_____________________
___ ___Problems with Scarring
Describe__________________
___ ___Ever use Accutane?
If Yes, when________________
___ ___Bruise easily?

Neuro

___ ___Blackouts/Fainting/Confusion
___ ___Seizures

Psychiatric

___ ___Severe Depression History
___ ___Prior Counseling

Endocrine

___ ___Diabetes
___ ___Thyroid Problems

Allergy/Immunologic

___ ___Latex Allergy
___ ___HIV / AIDS
___ ___Hepatitis ___A ___B ___C
___ ___Food Allergies
___ ___Use Recreational Drugs?

Hematologic/Lymphatic

___ ___Bleeding Disorders
___ ___Enlarged Lymph Nodes

______________________________ ______________________________ ________________
Dr. Barone's Signature **Patient's Signature** **Date**

Patient Photographic Authorization and Release

I, ______________________________, authorize Dr. Constance M. Barone and/or Constance M. Barone, M.D., F.A.C.S. and her representative(s), to take photographs, slides and/or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentation and/or articles.

I also authorize the use of these images, without compensation to me, for the following specific purposes: (Please initial in the boxes marked Yes or No for each item)

Yes	No	Medium
		In office *Photo Album* for prospective patients
		In office *Seminars* for prospective patients
		On Dr. Barone's *Website* for prospective patients
		In print Advertisements
		On *Television*
		Publication in *Books and Journals*

I further understand that:

1. These photographs, slides or videotapes may be published By Dr. Constance M. Barone and/or Constance M. Barone, M.D., F.A.C.S. in any print, visual, or electronic media including, but not limited to , medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Constance M. Barone, for which Dr. Barone may receive direct or indirect remuneration.

2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to Constance M. Barone, M.D., F.A.C.S.; 2829 Babcock Road, suite 615; San Antonio, Texas 78229. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.

______________________________________ ____________________

Patient's Signature **Date**

______________________________________ ____________________

Dr. Barone's Signature **Date**

Patient Photographic Authorization and Release (Continued)

4. I may refuse to sign this authorization without affecting the medical treatment I receive from Dr. Constance Barone.

5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

6. I release and discharge Dr. Constance Barone and/or Constance M. Barone, M.D., F.A.C.S. from all liability including liability for negligence, that in any way arises out of any and all rights that I may have or may have had in regards to the photographs, slides or videotapes of me including any claim for payment in connection with any publication of them in any medium. I release and hold harmless Dr. Constance M. Barone and Constance M. Barone, M.D., F.A.C.S., and her staff and her employees from any and all claims or causes of action that I may have of any nature whatsoever, which in any manner result from the use of the photographs or other images.

7. This Authorization is made as a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms and that Dr. Barone has answered all of my questions to my satisfaction.

______________________________ ______________

Patient's Signature **Date**

______________________________ ______________

Dr. Barone's Signature **Date**