MEDICAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____ Ext _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

ALIVE DECEASED	FATHER ☐ ☐	Present Health or Cause of Death	MOTHER ☐ ☐	Present Health or Cause of Death	SPOUSE ☐ ☐	Present Health or Cause of Death
BROTHERS	NO. ALIVE	HEALTH		HOW MANY DECEASED		CAUSE OF DEATH
SISTERS	NO. ALIVE	HEALTH		HOW MANY DECEASED		CAUSE OF DEATH
CHILDREN	NO. ALIVE	AGES & HEALTH		HOW MANY DECEASED		AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**

☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other

5 MEDICAL HISTORY

Check (✓) symptoms you currently have or have had in the past year. (All information is strictly confidential)

GENERAL

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations _____

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

_____

Pharmacy Name _____

Phone (_____) _____

List allergies to medications or substances _____

_____

_____

HEALTH HABITS

Check (✓) which you use and how much:

- ☐ Caffeine _____
- ☐ Street Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

Check (✓) if your work exposes you to:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

Your occupation _____

6 SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed by — Date

Hermosa Plastic Surgery

Patient Questionnaire

1. Are you concerned about your physical appearance? YES or NO
2. Do you think about your appearance all the time and wish you could think about it less? YES or NO
3. Please list the body areas you not like:

   _____

   _____

   _____
4. How many plastic surgeons have you seen? _____
5. Have you had plastic surgery before? _____
6. If you have had plastic surgery before, please list the procedures:

   _____

   _____
7. Were you satisfied with your prior surgeries?

   _____
8. Would you say one of your main concerns is being too thin? Or overweight?

   _____
9. How has this this problem with how you look affected your life?

   _____

   _____
10. Are you often upset about how you look? YES or NO
11. Has it often gotten in the way of your social and dating life? YES or NO
    If yes please describe:

    _____

    _____
12. Has it caused you any problems with school or work? YES or NO
    If yes please describe:

    _____

    _____
13. Are there things you avoid because of how you look? YES or NO
    If yes please describe:

    _____

    _____
14. On an average day, how much time do you usually spend thinking about how you look?
    - Less than 1 hour a day
    - 1-3 hours a day
    - More than 3 hours a day

Hermosa Plastic Surgery
Miguel L. Gallegos M.D.
8004 Constitution Pl NE
Albuquerque, NM 87110
Phone: (505) 924-2225
Fax: (505) 924-1063

Medical Photographs/ Video Tapes/ Slides

May be taken before, during or after any surgical procedure or treatment.

Consent is required to take such images.

1. **Consent to take photographs/slides/video tapes**

   I hereby authorize Dr. Miguel L. Gallegos M.D. and his associates or licensees to take pre-operative, intra-operative, and post-operative photographs.

2. **Consent for release of photographs/slides/video tapes**

   I hereby authorize Dr. Miguel L. Gallegos M.D. and his associates or licensees to use pre-operative, intra-operative, and post-operative photographs or video tapes for professional medical purposes deemed appropriate for medical education, patient education, lay publication or during lectures to medical lay groups.

   I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/ or my interview.

Date: _____

Patient Print Name: _____

Patient Signature: _____

Witness: _____

Acknowledgement of Receipt of Notice

Miguel L. Gallegos, MD
8004 Constitution Pl. N.E.
Albuquerque, NM 87110
(505) 924-2225

I hereby acknowledge that I read a copy of this medical practice's HIPPA Patient Rights.

I would like to receive a copy of any amended Notice of Privacy Practices by sending a request to Stacy Taylor, Privacy Officer, at the above address and phone number.

Yes_____ No_____

Signed: _____ Date: _____

Printed Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship to patient.

- Patient or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____

For office use Only:

Signed form received by: _____

Acknowledgement refused:

Efforts to obtain/ reasons for refusal:

_____

_____

Patient Consent for use of Credit, Debit Card, and Financing-Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies when requested to facilitate your payment.

Services that are preformed and are paid with a credit card, debit card or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Dr. Gallegos to use and disclose my protected health information to any credit card entity, bank, or financing company when requested to such information to process an account and assist with payment.

_____ (initial) I will not challenge such credit, debit, bank or financing card payments once the services have been provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

_____ (initial) I agree that his noncredit card challenge agreement is irrevocable.

X_____ (patient signature)

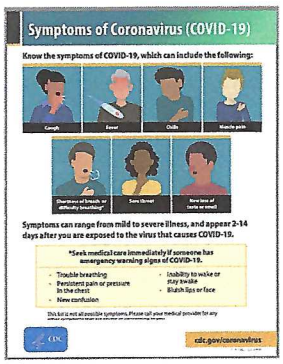
COVID-19 INFORMED CONSENT AGREEMENT

☐ **Risk of Exposure.** I, the undersigned individual, consent to an in-person consultation and/or to have my Doctor and/or his/her staff (hereinafter collectively "my Doctor") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand in-person consultations and/or having my procedure performed at this time, despite my own efforts and those of my Doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

☐ **Infection Control Procedures.** I also understand in-person consultations and/or having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my consultation and/or procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

☐ **Testing.** I have informed my Doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure.

☐ **Symptoms.** I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control here: https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf and printed on the reverse of this form, which information I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.



☐ **My Consents.** All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my in-person consultation and/or procedure until the COVID-19 pandemic is less prevalent, but I choose to have my in-person consultation and/or procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

☐ _____ _____

Individual/Patient/Authorized Representative Signature and Initials Print Name & Date **[First encounter]**

☐ _____ _____

Individual/Patient/Authorized Representative Signature and Initials Print Name & Date **[Day of procedure]**

The Aesthetic Society®

Notice and Disclaimer. Medical information changes constantly. This COVID-19 Informed Consent Agreement sets forth the current recommendations of The Aesthetic Society, is provided for informational purposes only, and does not establish a new standard of care. June 2, 2020