VIP
VILLAGE INSTITUTE of PLASTIC SURGERY

Patient Information Form

Legal Name:
(As it appears on ID) _____

Nick Name:
(How you addressed) _____

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

Home Phone: _____ Cell Phone: Cell Phone Carrier: _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

DOB & Age: _____ Race: _____ ☐ Asian ☐ African Amer. ☐ _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Sex: _____ SSN: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

Primary Care Physicians Phone Number: _____

Date of last exam (Annual, EKG, Labs, etc.) _____

Height: _____ Weight: _____

Preferred Pharmacy: _____ Phone Number: _____

How did you hear about our clinic? Please be as specific as possible by including names

☐ Billboard ☐ Patient Referral: _____ ☐ Seminar, Location:_____

☐ Valpak ☐ Friend: _____ ☐ Online, Which Site:_____

☐ Newspaper, _____ ☐ Dr. Referral: _____

☐ Other: _____

What is the nature of your visit? _____

_____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell : _____ Work : _____

Section I: Past Medical History

	Have you had or do you still have:	Yes	No	Description
1.	Cardiovascular - Heart Attack	☐	☐	
2.	Cardiovascular - Heart Stent placement	☐	☐	
3.	Cardiovascular - Heart Failure	☐	☐	
4.	Cardiovascular - Bypass Surgery (CABG)	☐	☐	
5.	Cardiovascular - Arrhythmia (such as A. Fibrillation)	☐	☐	
6.	Cardiovascular - Pacemaker Placement	☐	☐	
7.	Cardiovascular - Stroke	☐	☐	
8.	Cardiovascular - Aneurysm	☐	☐	
9.	Cardiovascular - Elevated Blood Pressure	☐	☐	
10.	Cardiovascular - Stress Test within last 5 years	☐	☐	☐ Abnormal ☐ Normal
11.	Cardiovascular - Heart Catheterization last 5 years	☐	☐	☐ Abnormal ☐ Normal
12.	Cardiovascular - Carotid Stenosis	☐	☐	
13.	Pulmonary - Emphysema or Chronic Bronchitis (COPD)	☐	☐	
14.	Pulmonary - Asthma	☐	☐	
15.	Pulmonary - COVID	☐	☐	
16.	Pulmonary - Oxygen Use at Home	☐	☐	
17.	Pulmonary - Obstructive Sleep Apnea	☐	☐	
18.	Pulmonary - Pulmonary Embolism	☐	☐	
19.	Pulmonary - Prior Tracheostomy	☐	☐	
20.	Infectious - Immune Deficiency	☐	☐	
21.	Infectious - HIV or AIDS	☐	☐	
22.	Infectious - Hepatitis B or C	☐	☐	
23.	Infectious - Prior Resistant Staph Infections (MRSA)	☐	☐	
24.	Infectious - Herpes/Cold Sores	☐	☐	
25.	Connective Tissue - Auto-Immune Disease	☐	☐	
26.	Connective Tissue - Cancer (other than skin)	☐	☐	
27.	Connective Tissue - Fibromyalgia	☐	☐	
28.	Connective Tissue - Chronic neck and/or back pain	☐	☐	
29.	Connective Tissue - Muscular Dystrophy (ALS) or Myasthenia gravis	☐	☐	
30.	Connective Tissue - Ehlers-Danlos Disease	☐	☐	
31.	Neurologic - Seizure Disorder	☐	☐	
32.	Neurologic - Migraine Headaches	☐	☐	
33.	Neurologic - Brain Surgery	☐	☐	
34.	Endocrine - Diabetes	☐	☐	

Section I: Past Medical History (continued)

	Have you had or do you still have:	Yes	No	Description
35.	Endocrine - Thyroid Problems	☐	☐	
36.	Endocrine - Hormone Replacement	☐	☐	
37.	Psychiatric - Hospitalization for Psychiatric Condition	☐	☐	
38.	Psychiatric - Major Depression	☐	☐	
39.	Psychiatric - Schizophrenia	☐	☐	
40.	Psychiatric - Bipolar Disorder	☐	☐	
41.	Skin - Prior Skin Cancer	☐	☐	
42.	Skin - Prior Skin Resurfacing (Laser, Chemical peel, or Dermabrasion)	☐	☐	
43.	Skin - Acutane (isotretinoin) use within the last year	☐	☐	
44.	Hematologic - Abnormal Bleeding (Bleeding Disorder)	☐	☐	
45.	Hematologic - Blood Clots	☐	☐	
46.	Hematologic - Anemia	☐	☐	
47.	Hematologic - Leukemia or Lymphoma	☐	☐	
48.	Hematologic - Current blood thinner use	☐	☐	
49.	Renal - Kidney Failure	☐	☐	
50.	Renal - Kidney Transplant	☐	☐	
51.	Hepatic - Liver Failure	☐	☐	
52.	Ophthalmologic - Chronic Dry Eyes	☐	☐	
53.	Ophthalmologic - Sjögren's Syndrome	☐	☐	
54.	Ophthalmologic - Prior Eye Surgeries	☐	☐	
55.	Other - Severe reaction to Anesthesia	☐	☐	

56. Others Not Listed: _____

Section II: Past Surgical History

1. Have you ever had surgery? ☐ No ☐ Yes, PLEASE LIST SURGERIES ALONG WITH DATES**:**

2. Have you or a blood relative of yours ever had reactions to anesthesia of any kind? ☐ No ☐ Yes, please describe:

Section III: Allergies

Are you allergic to any medications or substances? ☐ No ☐ Yes, **PLEASE LIST** and **INCLUDE REACTION**

Have you ever had any bad reactions to anesthesia? ☐ No ☐ Yes, please explain

Section IV: Current Medications & Supplements

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, **PLEASE LIST**:

Section V: Social History

1. Do you smoke? ☐ Never ☐ Secondhand Smoke ☐ Current Smoker, how much? _____
   ☐ Smoke off and on ☐ Smokeless Tobacco ☐ Quit Date: _____
2. Do you drink? ☐ No ☐ Yes, how much? ☐ Rarely ☐ 1-2 per week ☐ 3x a week ☐ Daily ☐ Occasionally
3. Do you exercise ? ☐ Rarely ☐ Once/week ☐ 3 times a week ☐ Daily
4. Do you drink caffeine? ☐ No ☐ Yes, how much?
5. Do you use any recreational drugs? ☐ No ☐ Yes, what kind?

Women Only

1. Are you currently pregnant?: ☐ No ☐ Yes Have you been pregnant before? ☐ No ☐ Yes If yes, how many times? _____ What was the year that you gave birth and were deliveries natural or by cesarian section :

Section VI: Family History

	Have any blood relatives had any of the following?	Yes	No	Description/Relative
1.	Bleeding Disorder	☐	☐	
2.	Blood Clots	☐	☐	
3.	Cancer	☐	☐	
4.	Diabetes	☐	☐	
5.	Heart Disease	☐	☐	
6.	Stroke	☐	☐	
7.	Others Not Listed:			

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

Consent to Communicate

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders				
☐ Email Medical Info				
☐ Email Marketing Info				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Page	-	-	☐	-
☐ Text Appt Reminders – if so, list cell carrier:				
☐ Text Marketing Info – if so, list cell carrier:				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____ _____

VIP COVID-19 PRECAUTIONS & GUIDELINES:

Dear Valued Patient,

The spread of the viral illness COVID-19, caused by the Sars-CoV-2 virus, has caused widespread community outbreaks throughout the country. As a healthcare facility, we consider the risks relating to COVID-19 carefully and have taken precautions to ensure that patient safety is maximized. Our current COVID-19 safety protocols follow established CDC guidelines and depend on the levels of community transmission for Lake County, FL.

Definition of Transmission Levels:

Determining COVID-19 Community Levels

New Cases[1] (per 100,000 population in the last 7 days)	Indicator	Low	Medium	High
<200 cases	New COVID-19 admissions per 100,000 population (7-day total)[2]	<10.0	10.0-19.9	≥20.0
	Percent of staffed inpatient beds in use by COVID-19 patients (7-day average)[3]	<10.0%	10.0-14.9%	≥15.0%
≥200 cases	New COVID-19 admissions per 100,000 population (7-day total)	NA	<10.0	≥10.0
	Percent of staffed inpatient beds in use by COVID-19 patients (7-day average)	NA	<10.0%	≥10.0%

Precautions – Low Level:

- Screening of patients for COVID diagnosis/exposure within 10 days from appointment with cancellation and postponement for a minimum of 2 weeks.
- Confirmatory in-person screening of patients for COVID diagnosis/exposure.
- Availability of hand sanitizer for all patients
- Availability of masks to patients upon request
- Disinfection of all surfaces with high-grade, virucidal chemical disinfectants
- UV-C purification of all circulating air within the clinic during operation

Precautions – Medium Level:

- Low Level precautions with the following additional precautions
- Maintaining a waiting room free of crowding with no more than 4 individuals at maximum
- Institution of masking recommendation for all staff

Precautions – High Level:

- Medium Level precautions with the following additional precautions
- Maintaining a waiting room free of crowding with no more than 2 individuals at maximum
    - Mandatory masking for all staff with K/N95 masking recommended
    - Temperature screenings for all patients
    - Minimization of in-clinic and preferential use of telehealth whenever appropriate

By signing below, you acknowledge that you have read these COVID-related precautions and understand the intrinsic risk that exists in obtaining care through VIP. In addition, you acknowledge that your appointment may need to be cancelled and rescheduled for any symptoms deemed potentially related to COVID illness, judged by our clinical staff, and potential requirement for COVID testing prior to being eligible for treatment at VIP.

Patient Initials: _____

In addition, by signing below, you acknowledge that, in the last 2 weeks, you have not had any symptoms of respiratory illness, such as cough, shortness of breath, sinus congestion, sore throat, fevers/chills, new- onset generalized malaise or body aches, diarrhea/vomiting, sudden loss of smell or taste, and that, in the last 4 weeks you have not had exposure to a person testing positive for COVID-19 and have not tested positive for COVID-19 yourself.

Patient Initials: _____

Patient Signature: _____ Date: _____

HIPAA Information and Consent Form

Patient Name:

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, Brittany Pariente, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____ _____