



9735 WILSHIRE BLVD, STE 308, BEVERLY HILLS, CA 90212 310.247.3777  
 15503 VENTURA BLVD, STE 370, ENCINO, CA 91436 818.501.4550

Date \_\_\_\_\_

**PATIENT INFORMATION**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Sex: M / F Marital Status: M S D W P

Soc. Sec. No. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Home Street Address \_\_\_\_\_

Home City, State, Zip Code \_\_\_\_\_

Preferred Contact #: Cell Home Work Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ leave msg? Y/N Work Phone \_\_\_\_\_ leave msg? Y/N

Email Address \_\_\_\_\_ **Add to E-Mail List for newsletter & specials? Y / N**

Emergency Contact: \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about our practice?

Doctor: \_\_\_\_\_ Friend/Family: \_\_\_\_\_ Internet/Website: \_\_\_\_\_

**REASON FOR VISIT:**

Main Reason: \_\_\_\_\_

Other Concerns / Areas of Interest: (check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Forehead Lines     | <input type="checkbox"/> Jowls                 | <input type="checkbox"/> Facelift         |
| <input type="checkbox"/> Frown Lines        | <input type="checkbox"/> Sun Damage            | <input type="checkbox"/> Necklift         |
| <input type="checkbox"/> Crows Feet         | <input type="checkbox"/> Brown Spots           | <input type="checkbox"/> Cheeklift        |
| <input type="checkbox"/> Low Eyebrows       | <input type="checkbox"/> Fine Lines / Wrinkles | <input type="checkbox"/> Eyelid Lift      |
| <input type="checkbox"/> Droopy Eyelids     | <input type="checkbox"/> Skin Cancer           | <input type="checkbox"/> Browlift         |
| <input type="checkbox"/> Excess Eyelid Skin | <input type="checkbox"/> Sun Protection        | <input type="checkbox"/> Lip Augmentation |
| <input type="checkbox"/> Under Eye Bags     | <input type="checkbox"/> Excessive Sweating    | <input type="checkbox"/> Lip Lift         |
| <input type="checkbox"/> Under Eye Darkness | <input type="checkbox"/> Smile Lines           | <input type="checkbox"/> Facial Implants  |
| <input type="checkbox"/> Angry / Tired Look | <input type="checkbox"/> BOTOX Cosmetic®       | <input type="checkbox"/> Fat Transfer     |
| <input type="checkbox"/> Sunken Cheeks      | <input type="checkbox"/> Skin Fillers/Plumpers |   |
| <input type="checkbox"/> Thin Lips          |  |   |

**CONSULTATION QUESTIONNAIRE**

My three (3) biggest concerns are:

- |                        |                             |                 |
|------------------------|-----------------------------|-----------------|
| the doctor's abilities | looking unnatural           | taking time off |
| the discomfort         | telling my spouse or others | the cost        |
| anesthesia             | people noticing             | the scars       |

How soon are you interested in receiving your procedure or treatment? \_\_\_\_\_

Do you have any particular date(s) in mind? Yes / No \_\_\_\_\_

Are you getting ready for a special event? Yes / No \_\_\_\_\_

Would you like information on financing options? Yes / No \_\_\_\_\_



# JONATHAN A. HOENIG, MD

## OCULOFACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Patient Name \_\_\_\_\_

Today's Date \_\_\_\_\_

### MEDICAL INFORMATION

Height \_\_\_\_\_ Weight \_\_\_\_\_ For you, is this weight Normal \_\_\_\_\_ Low \_\_\_\_\_ High \_\_\_\_\_

Do you now or have you ever smoked? N / Y How much and for how long? \_\_\_\_\_

Do you drink alcohol? Never \_\_\_\_\_ Rarely \_\_\_\_\_ Frequently \_\_\_\_\_ Daily \_\_\_\_\_

Do you use recreational drugs? N / Y If yes, what types and how often? \_\_\_\_\_

Have you have ANY DRUG OR LATEX ALLERGIES, or reactions to any medicines? No / Yes

If yes, please list allergy and reaction: \_\_\_\_\_

Please list any PRESCRIPTION medications you take on a regular or occasional basis:

Please list any OVER THE COUNTER MEDICATIONS, HERBS OR VITAMINS you take:

- Have you or a family member had problems with anesthesia? No / Yes \_\_\_\_\_
- When you go to the dentist, do you have a hard time getting or staying numb? No / Yes \_\_\_\_\_
- Do you have bruising or bleeding problems? No / Yes \_\_\_\_\_

### REVIEW OF SYMPTOMS and MEDICAL HISTORY

Circle any and all of the following symptoms you have or have had in the past year:

weight loss	double vision	hearing loss	bruise easily
fever	dry eyes	ringing in ears	rashes
night sweats	eye redness	sore throat	change in moles
depression	eye pain	bloody nose	scars
heart palpitations	chronic cough	constipation	frequent urination
chest pain	bloody sputum	diarrhea	blood in urine
heart racing	short of breath	blood in stools	painful urination
ankle swelling	wheezing	excessive thirst	lost bladder control
headaches	joint pain	bleeding gums	allergic swelling
dizziness	muscle pain	unexplained bleed	hives
numbness	weak arms/legs	transfusion	other: _____

Please circle any and all of the following conditions you have now or have had in the past

HIV + or AIDS	ulcers or heartburn	heart disease
irregular heartbeat	high blood pressure	kidney disease
heart murmur	psychiatric care	asthma or emphysema
heart attack	thyroid problems	tuberculosis
stroke	diabetes	hepatitis or liver disease
seizures	arthritis	alcohol or drug addiction
cancer (please specify type and treatment)	_____	

other conditions \_\_\_\_\_

**\*\*\*IF NONE OF THE ABOVE APPLY, PLEASE INITIAL HERE:\_\_\_\_\_**



Patient Name \_\_\_\_\_

Today's Date \_\_\_\_\_

**EYE AND FACIAL HISTORY**

Do you have any visual problems?	Y / N	Have you had Bell's Palsy?	Y / N
Do you wear glasses or contacts?	Y / N	Have you had any injury to your eyes?	Y / N
Do you have dry or watery eyes?	Y / N	Have you ever had cataracts?	Y / N
Do you have glaucoma?	Y / N	Have you had laser or other eye surgery?	Y / N

**PAST SURGICAL HISTORY** (please list all previous surgeries that you have had)

Date _____	Surgery _____	Doctor _____
Date _____	Surgery _____	Doctor _____
Date _____	Surgery _____	Doctor _____
Date _____	Surgery _____	Doctor _____

**CURRENT PHYSICIAN(S)**

Name _____	Phone #: _____
Name _____	Phone #: _____

Please provide any additional information you think we should know: \_\_\_\_\_

I understand that the above answers are important for my safety during and after surgery or medical care and I, therefore, certify that all of the above answers are true to the best of my knowledge.

Print Full Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**PHOTOGRAPHIC CONSENT** –*Dr. Hoenig cannot perform any procedures without a signed consent*  
In connection with the medical services that I am receiving from Jonathan Hoenig, MD, I consent that photographs and/or or videos may be taken of me before and after treatments. These photos or videos may be used for:

- my medical records only \_\_\_\_\_ (initial)
- my medical records AND any print, visual, or electronic media including but not limited to medical journals textbooks, education and marketing materials, public and private websites, TV shows, and magazines \_\_\_\_\_ (optional, initial if yes)

Print Full Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**MISSED APPOINTMENT AND CANCELLATION POLICY**

In order to be respectful of the needs of other patients, our office requires a 2 business day notice of cancellation of your appointment. In the event that you miss or fail to cancel one your appointments in a timely manner, a fee of \$100 will be charged. This fee must be paid prior to scheduling future appointments.

If you arrive more than 20 minutes late, we may have to reschedule your appointment. Exceptions to this policy will be made on a case-by-case basis. Thank you for your understanding.

Credit Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_



Patient Name \_\_\_\_\_

Today's Date \_\_\_\_\_

### **HIPAA ACKNOWLEDGEMENT AND NOTICE OF PRIVACY PRACTICES**

This is a general summary of our privacy practices and describes in brief how medical information about you may be used and disclosed and how you can get access to this information. The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you.

The law requires us to 1) keep your medical information private, 2) provide or post a copy of the full notice describing our legal duties, privacy practices, and your rights regarding medical information, and 3) follow the terms of the current notice.

We have the right to 1) change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law and 2) make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

You have the right to:

1. Look at or get copies of certain parts of your medical information. You must make your request in writing. There may be a service charge for copies of medical records. Please allow at least 5-7 business days for copies to be prepared.
2. Receive a list of all the times we shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions on our use or disclosure of your medical information, but if we do, we will abide by our agreement.
4. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
5. If you have received this notice electronically and you wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to us.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

Print Full Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_