JONATHAN A. HOENIG, MD
OCULOFACIAL PLASTIC & RECONSTRUCTIVE SURGERY

9735 WILSHIRE BLVD, STE 308, BEVERLY HILLS, CA 90212 310.247.3777 FAX 310.247.3778
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

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 _____ **E-Mail newsletter & specials? Y / N**

Emergency Contact: _____ Relation _____ Phone _____

How did you hear about our practice? (please provide name, when possible)

Doctor: _____ Friend/Family: _____ Internet: _____

REASON FOR VISIT:

Main Reason: _____

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

_____ Forehead Lines
_____ Frown Lines
_____ Crows Feet
_____ Low Eyebrows
_____ Droopy Eyelids
_____ Excess Eyelid Skin
_____ Under Eye Bags
_____ Under Eye Darkness
_____ Angry / Tired Look
_____ Sunken Cheeks
_____ Jowls

_____ Sun Damage
_____ Brown Spots
_____ Fine Lines / Wrinkles
_____ Skin Cancer
_____ Sun Protection
_____ Excessive Sweating
_____ Smile Lines
_____ BOTOX Cosmetic®
_____ Skin Fillers / Plumpers
_____ Thin Lips

_____ Necklift
_____ Facelift
_____ Cheeklift
_____ Eyelid Lift
_____ Browlift
_____ Lip Augmentation
_____ Lip Lift
_____ Facial Implants
_____ Fat Transfer
Other:
_____

CONSULTATION QUESTIONNAIRE

My three (3) biggest concerns are:

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

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 _____

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

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:_____

******IF NONE OF THE ABOVE SYMPTOMS APPLY, PLEASE INITIAL HERE: :_____***

JONATHAN A. HOENIG, MD
OCULOFACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Patient Name _____

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 CONDITIONS APPLY, PLEASE INITIAL HERE:*** _____

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 _____

JONATHAN A. HOENIG, MD
OCULOFACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Patient Name _____

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.

You may call 310-247-3777 or 818-501-4550 and leave a message or email info@drhoenig.com at any time when you realize that you will be unable to keep your scheduled appointment.
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.

Signature _____

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 _____