JONATHAN A. HOENIG, MD
OCULOFACIAL PLASTIC & RECONSTRUCTIVE SURGERY

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

Date _____

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Date of Birth ____/____/_____ Age _____ Sex: M / F Marital Status: M S D W P

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 _____

Soc. Sec. No. _____-____-_____ Occupation_____ Employer_____

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

Doctor: _____ Friend/Family: _____ Internet/Website:_____

REASON FOR VISIT:

Main Reason:_____

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

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

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

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Patient Name _____ Today's Date _____

MEDICAL INFORMATION

Height _____ Weight _____ For you, is this … Normal _____ Low _____ High _____

Have you had 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:

_____

Nicotine: [ ]-Current every day nicotine [ ]-Current some days use [ ]-Former smoker [ ]-Never used

Alcohol Use: [ ] Never [ ] Rarely [ ] Frequently [ ] Daily

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

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:*** _____

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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 #: _____

PREFERRED PHARMACY

Name _____ Location _____ Phone #: _____

Please provide any additional information you think we should know:_____

_____

I understand that the above answers are important for my safety and I, therefore, certify that all 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 photo 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. If 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.

Print Name _____ Signature _____ Date _____

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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 that 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 the purposes set out in our Notice.

Print Full Name _____ Signature _____ Date _____