

I. PATIENT INFORMATION

Name: _____ Date of Birth: _____
Address: _____ Social Security Number: _____
City, State, Zip: _____ Marital Status: _____
Home Phone: _____ Occupation: _____
Work Phone: _____ Contact Person & Phone: _____
Cell Phone: _____ Primary Care Physician: _____
Email Address: _____

II. HISTORY

1. Of what ancestry are you? (English, Russian, etc.): _____
2. Do you regularly sunbathe or go to tanning booths or use tanning creams?.....Yes No
If so, do you tan easily?(Light) 1 2 3 4 (Dark)
3. If you do tan, is the tan even or blotchy?(Even) 1 2 3 4 (Blotchy)
4. Have you ever had facial or neck x-ray treatment for acne or any other reason?.....Yes No
5. Have you ever had dermabrasion or a chemical peel?.....Yes No
If so, when, where, and by whom? _____
6. Are you currently using or have you ever used Retin-A?Yes No
If yes, when started? _____ Stopped when? _____
7. Are you currently using or have you ever used Accutane?Yes No
If yes, when started? _____ Stopped when? _____
8. Do you smoke or have poor circulation?.....Yes No
9. Do you have any skin disorders?.....Yes No
If yes, please explain: _____
10. Do you have or have you ever had eczema, seborrhea or psoriasis?Yes No
11. Do you have or have you ever had vitiligo (loss of skin pigment)?.....Yes No
12. Do you ever get "herpes" skin eruptions or cold sores?.....Yes No
13. Are you a keloid former (extra large scars)?.....Yes No
14. Have you ever had any problems with cosmetic treatments or surgery in the past?.....Yes No
If yes, please explain: _____

III. SOCIAL HISTORY

Do you now smoke, or have you smoked in the past?.....Yes No
If so, how much? _____
What is your average weekly alcoholic beverage consumption? _____

IV. MEDICAL HISTORY (Place a check if you have, or have been treated for:)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Stroke/circulation problems | <input type="checkbox"/> Endocrine/Hormonal | <input type="checkbox"/> Other: _____ | |

V. SURGICAL HISTORY

Please list any surgery (including laser treatments and all cosmetic procedures) you have undergone and the date(s).

VI. MEDICATIONS

Have you ever had a reaction to general or local anesthetic?.....Yes No

If so, please explain:_____

Are you allergic to any medicine?.....Yes No

If so, please list medicine and reaction (including topical creams/ointments, etc.):

List all medications you currently take and the dosage of each. Please refer to your prescription labels for accuracy. Include **both prescriptions and over-the-counter medications** of any form.

VII. SKIN TYPE (Circle one from each column)

<u>TYPE</u>	<u>SKIN TYPE</u>	<u>EYES</u>	<u>HAIR COLOR</u>	<u>REACTION TO FIRST SUN EXPOSURE</u>
I	Very light	Blue	Red	Always burn, never tans
II	Light	Green	Blonde	Usually burn, tan with difficulty
III	Medium	Brown	Light brown	Sometimes mild burn, tan average
IV	Medium-dark	Black	Brown	Rarely burn, tan with ease
V	Dark brown		Brown-black	Rarely burn, tan very easily
VI	Black		Black	Never burn, tan very easily

III. EXPECTATIONS

1. Please explain briefly where and what type of improvement you desire (i.e. eye area, diminish wrinkles, lips, etc.): _____

2. How rapidly would you like to see improvement?.....(Immediate) 1 2 3 4 (Gradual)

3. Can you be out of circulation, and if so, for how long (Not seen in public)? _____

4. Is scabbing acceptable in the post-treatment phase?.....Yes No

The information given above is true, complete, and accurate to the best of my knowledge.

Patient/Guarantor Signature:_____ Date:_____

PATIENT PHOTOGRAPHY CONSENT

I, _____ hereby give my permission to Enzer & Associates, P.C. (i.e. Dr. Enzer or his associates) to photograph me for ***diagnostic purposes and for medical records***. I authorize the use of the photographs for teaching purposes or to illustrate scientific papers or medical books at any time hereafter without inspection or approval on my part, of the finished product or specific use to which these photographs may be applied. I hereby consent to any or all of the above.

SIGNATURE OF PATIENT

DATED SIGNED

Please note:

As part of your examination, Enzer & Associates, P. C. (i.e. Dr. Enzer or his associates) routinely take photographs for *diagnostic purposes that also serve as part of your medical record and documentation for your insurance company.*

Being actively involved in medical education and research publication, it is occasionally necessary to use "real life" cases as examples. The name of the patient is never disclosed and in most circumstances the photographs are extreme close-ups of the eye area, not full face views.

YOASH R. ENZER, MD, FACS

Enzer & Associates, PC

Ophthalmic Plastic and Reconstructive Surgery

Orbital and Lacrimal Surgery

Cosmetic Surgery

Southside Medical Center

120 Dudley Street, Suite #104

Providence, RI 02905

401-274-4464

APPOINTMENT POLICY

EFFECTIVE OCTOBER 1, 2006, our appointment policy for all patients will change. Unlike many doctor offices, we do not overbook our patients. We work very hard to arrange our schedule such that our patients do not wait unreasonable periods of time. These reserved time slots are booked especially for you, our valued patients. As a courtesy, we make every effort to give our patients a reminder call several days in advance. Unfortunately, there have been too many instances where the doctor or his staff waits for patients who do not adhere to our current 24-hour cancellation policy, simply not showing up. The lack of a courtesy call is also unjust to our many patients who have to wait weeks or months for an appointment. Additionally, leaving a message with our answering service the night before a scheduled appointment *does not* constitute a 24-hour notice. Therefore, we feel an improvement is necessary.

The following fees will be charged for all missed appointments, not cancelled 24-hours prior to your scheduled time with either Dr. Enzer, our nurse, or our estheticians:

Dr. Enzer: 15 minute appointment = \$ 50.00
 30 minute appointment = \$100.00
 45 minute appointment = \$150.00

Registered Nurse: 30 minute appointment = \$ 50.00

Estheticians: One half of treatment cost

You may either put this charge on a credit card, or should you wished to be billed, there will be an additional \$25.00 fee from our billing company. This must be paid in full before booking another appointment.

As always, we strive to provide the best care to our patients, and thank you for your understanding in this matter.

Patient's Name (Printed)

Date of Signature

Patient's Signature

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have had the opportunity to read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I also reserve the right how I want to be contacted:

- I give permission for your office to contact me by phone or by mail as listed on my patient information sheet.
- Dr Enzer should contact me as follows: _____
- Dr. Enzer’s office should not make any attempt to contact me. I assume full financial responsibility for any and all missed appointments.

Patient’s Name (or if Minor: Parent/Guardian)

Patient (or Representative) Signature

Date of Signature

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Reason:	Initials:
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