ROBINSON FACIAL
PLASTIC SURGERY

PATIENT HEALTH HISTORY

Date: ____

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **PLEASE FILL OUT EVERY ITEM.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name ________________________________First ___________________MI_____ SSN#__________________

Sex ☐ M ☐ F DOB_____/______/______ Weight:_________ Height:____________

Pharmacy Contact:____

Name of Referring Physician ___________________ Name of Primary Care Physician_________________________________

REASON FOR VISIT TODAY____

Are you taking ANY kind of medication now? (This includes prescription, topical, over-the-counter or herbal medications)
☐ **No** ☐ **Yes** If yes, please list below. If you run out of room, use the back of this sheet for additional information.
PLEASE LIST ALL MEDICATIONS CURRENTLY BEING USED (PLEASE PRINT NEATLY)

Name of drug	Dosage	How often taken

Have you ever been on Accutane? ☐ **No** ☐ **Yes** If yes, when was your last dose? _____________________
Are you currently taking Coumadin, aspirin or aspirin containing medications? ☐ **No** ☐ **Yes**

Are you allergic to ANY medication? ☐ **No** ☐ **Yes** If yes, please list below.

Name of Medication	Type of Reaction

NON-MEDICATION ALLERGIES:

Are you allergic to: Latex Gloves? ☐ **No** ☐ **Yes** Tape? ☐ **No** ☐ **Yes** Contrast Dye? ☐ **No** ☐ **Yes**
Are you allergic to any foods? If yes, please describe____
Have you had any allergy testing in the past? ☐ **No** ☐ **Yes** If yes, which type? Skin tests ☐ Blood tests ☐
Are you currently taking Allergy Shots? ☐ **No** ☐ **Yes**

PAST HEALTH HISTORY:

Have you ever been ***DIAGNOSED*** with any major health problems? Indicate below:

Cancer (type) ____

HEAD and FACE:

Cluster headache ☐ **No** ☐ **Yes**
Migraine headache ☐ **No** ☐ **Yes**

EYES:

Cataracts ☐ **No** ☐ **Yes**
Glaucoma ☐ **No** ☐ **Yes**
Dry Eyes ☐ **No** ☐ **Yes**

EARS:

Hearing loss from aging ☐ **No** ☐ **Yes**
Hearing loss from trauma ☐ **No** ☐ **Yes**
Chronic ear infections ☐ **No** ☐ **Yes**
Meniere's disease ☐ **No** ☐ **Yes**

LUNGS and RESPIRATORY:

Asthma ☐ **No** ☐ **Yes**
Chronic Bronchitis ☐ **No** ☐ **Yes**
Emphysema ☐ **No** ☐ **Yes**

STOMACH and DIGESTIVE:

Gastrointestinal reflux ☐ **No** ☐ **Yes**
Gallbladder inflammation (Cholecystitis) ☐ **No** ☐ **Yes**
Stomach ulcer ☐ **No** ☐ **Yes**

KIDNEY and/or GENDER SPECIFIC:

Endometriosis ☐ **No** ☐ **Yes**
Kidney stones ☐ **No** ☐ **Yes**
Prostate enlargement ☐ **No** ☐ **Yes**
Renal failure ☐ **No** ☐ **Yes**
Are you pregnant? ☐ **No** ☐ **Yes**

BONES, JOINTS and MUSCLES:

Arthritis ☐ **No** ☐ **Yes**
Degenerative bone disease ☐ **No** ☐ **Yes**

SKIN and/or BREASTS:

Psoriasis ☐ **No** ☐ **Yes**
Scleroderma ☐ **No** ☐ **Yes**
Shingles ☐ **No** ☐ **Yes**

NOSE and SINUS:

Nasal Allergies ☐ **No** ☐ **Yes**
Deviated Septum ☐ **No** ☐ **Yes**
Chronic Sinusitis ☐ **No** ☐ **Yes**
Recurrent Sinusitis ☐ **No** ☐ **Yes**

MOUTH and THROAT:

Chronic Tonsillitis ☐ **No** ☐ **Yes**
Recurrent Tonsillitis ☐ **No** ☐ **Yes**
Sleep Apnea ☐ **No** ☐ **Yes**

HEART and BLOOD VESSELS:

Heart Attack ☐ **No** ☐ **Yes**
Hypertension ☐ **No** ☐ **Yes**
Elevated Cholesterol ☐ **No** ☐ **Yes**

BRAIN and NERVOUS SYSTEM:

Epilepsy ☐ **No** ☐ **Yes**
Multiple Sclerosis ☐ **No** ☐ **Yes**
Stroke ☐ **No** ☐ **Yes**

MENTAL and EMOTIONAL HEALTH:

Anorexia ☐ **No** ☐ **Yes**
Anxiety ☐ **No** ☐ **Yes**
Bulimia ☐ **No** ☐ **Yes**
Depression ☐ **No** ☐ **Yes**

GLANDS, HORMONES & SUGAR CONTROL:

Diabetes(unsure of type) ☐ **No** ☐ **Yes**
Diabetes (type I) ☐ **No** ☐ **Yes**
Diabetes (type II) ☐ **No** ☐ **Yes**
Graves Disease ☐ **No** ☐ **Yes**
Thyroid deficiency ☐ **No** ☐ **Yes**
Thyroid excess ☐ **No** ☐ **Yes**

BLOOD and LYMPH NODE:

Anemia (unknown cause) ☐ **No** ☐ **Yes**
Anemia (iron deficiency) ☐ **No** ☐ **Yes**

ALLERGIES, IMMUNE or INFECTIOUS PROBLEMS:

AIDS ☐ **No** ☐ **Yes**
HIV ☐ **No** ☐ **Yes**
Infectious Mononucleosis ☐ **No** ☐ **Yes**

DIAGNOSIS NOT LISTED:____

SURGERIES AND HOSPITALIZATIONS:

Have you been hospitalized for a medical problem before? ☐ **No** ☐ **Yes**
If yes, list hospitalizations, the reason for admission and the date: ______________________________
Have you ever had surgery? ☐ **No** ☐ **Yes**
If yes, mark any of the following you have had:
Sinus surgery? ☐ **No** ☐ **Yes,** dates:____________________ Tonsillectomy? ☐ **No** ☐ **Yes,** date:______________________
Facial Plastic Surgery? ☐ **No** ☐ **Yes** If yes, please tell us procedure and dates ______________________________
____
Other types of surgeries? ____
Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ **No** ☐ **Yes**
If yes, please list what sort of problems. ____

SERIOUS INJURIES:

Have you ever had a serious injury such as face, head, neck, back, or other injury? ☐ **No** ☐ **Yes**

If yes, list and describe the type of injury and when it occurred: ____

FAMILY HISTORY:

☐ **No Family History of Significant or Pertinent Health Problems:**

Specific Anesthesia Problem: ☐Mother ☐Father ☐Brother ☐Sister

Head and Face:

Headache ☐Mother ☐Father ☐Brother ☐Sister

Ears:

Hearing Loss before age 20 ☐Mother ☐Father ☐Brother ☐Sister

Hearing Loss after age 20 ☐Mother ☐Father ☐Brother ☐Sister

Nose and Sinus:

Chronic Sinus Disease (had surgery) ☐Mother ☐Father ☐Brother ☐Sister

Chronic Sinus Disease (no surgery) ☐Mother ☐Father ☐Brother ☐Sister

Heart and Blood Vessels:

Heart Disease ☐Mother ☐Father ☐Brother ☐Sister

High Blood Pressure ☐Mother ☐Father ☐Brother ☐Sister

Lungs & Respiratory:

Asthma ☐Mother ☐Father ☐Brother ☐Sister

Lung Cancer ☐Mother ☐Father ☐Brother ☐Sister

Brain and Nervous:

Stroke ☐Mother ☐Father ☐Brother ☐Sister

Blood & Lymph Node Problems:

Bleeding/clotting problems

☐Mother ☐Father ☐Brother ☐Sister

OTHER PERTINENT FAMILY HISTORY:

____

____

____

____

SOCIAL HISTORY:

Marital Status______________________________ What is or was your occupation? ____

Check here if you are retired: ☐

Have you ever used tobacco in any form? ☐ **No** ☐ **Yes** If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _________		
Other: (list type) ___________		

Have you ever used alcohol in any form? ☐ **No** ☐ **Yes** If yes, please complete the following:

Type of Alcohol	From year	To year
Beers per week:____________		
Wine glasses per week:________		
Other: (list type) ___________		

Do you use drugs recreationally? ☐ **No** ☐ **Yes**

Caffeine use: ☐ None ☐ About 1 cup/day ☐ 2-3 cups/day ☐ 4 or more cups/day ☐ other __________________________

REVIEW OF SYSTEMS: CHECK any problems you have or have had recently in the following areas:

General health problems: ☐ **No** ☐ **Yes**
(☐ fever ☐ sleeping problems ☐ unintentional weight loss)

Head or Face Problems: ☐ **No** ☐ **Yes**
(☐ headaches ☐ face pain ☐ skin lesions)

Eye Problems: ☐ **No** ☐ **Yes**
(☐ blurred vision ☐ double vision ☐ loss of vision)

Ear Problems: ☐ **No** ☐ **Yes**
(☐ hearing loss ☐ dizziness ☐ ringing)

Nose & Sinus: ☐ **No** ☐ **Yes**
(☐ frequent colds ☐ frequent nosebleeds ☐ frequent runny nose ☐ itchy nose ☐ sinus drainage)

Mouth and Throat: ☐ **No** ☐ **Yes**
(☐ change in voice ☐ snoring ☐ sore throat)

Neck Problems: ☐ **No** ☐ **Yes**
(☐ neck masses or lumps ☐ pain ☐ swollen glands)

Heart or Circulation: ☐ **No** ☐ **Yes**
(☐ fainting ☐ bluish color of lips or nails ☐ chest pain ☐ irregular heartbeat ☐ leg cramps ☐ swelling ankles)

Stomach problems: ☐ **No** ☐ **Yes**
(☐ abdominal pain ☐ diarrhea ☐ heartburn ☐ nausea ☐ vomiting)

Bones, Joints and Muscles: ☐ **No** ☐ **Yes**
(☐ pain in back ☐ painful joints ☐ stiffness ☐ swelling joints)

Brain or Nervous System: ☐ **No** ☐ **Yes**
(☐ change in alertness ☐loss of consciousness ☐numbness ☐ seizures ☐ weakness)

Problems with Glands, Hormones: ☐ **No** ☐ **Yes**
(☐ feel cold all the time ☐ feel hot when others are not ☐ increased appetite ☐ increased fatigue ☐ neck has enlarged ☐ unwanted weight change)

Problems with Blood or Lymph nodes: ☐ **No** ☐ **Yes**
(☐ bleeds excessively after injury ☐ bruises easily)

Problems with Allergies: ☐ **No** ☐ **Yes**
(☐ food intolerances ☐ freq sneezing ☐ hives ☐ post nasal drainage ☐ severe reaction to insect bites)

Lung or Respiratory: ☐ **No** ☐ **Yes**
(☐ freq non-productive cough ☐ freq productive cough ☐ shortness of breath ☐ wheezing)

Problem not listed: ____

ROBINSON FACIAL
PLASTIC SURGERY

Patient's Name: ____ DOB:__________________

HIPAA – PRIVACY POLICY

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide our patients the highest quality medical care possible. Patients should not be afraid to provide information to or practice and its physicians and staff for purposes of treatment, payment, and healthcare operations. Our HIPAA policy in its entirety can be obtained through our office. Please let us know if you would like to receive a copy before signing this consent.

OFFICE POLICY ON MANAGED CARE INSURERS

We are pleased to meet the needs of our patients and referring physicians by enrolling with numerous managed care insurance programs. While we are able to provide you with this service, it is extremely difficult to keep track of all the individual requirements of each plan. Even with the same insurance company the plans may differ. Providing quality medical care for our patients is our primary concern, and we are more than willing to provide that care within your insurance contract guidelines if you let us know at each visit what those guidelines are.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently provide services, or order services such as lab work or hospitalization that are not covered, we or the medical facility will have no choice but to bill you directly for those charges. All fees submitted and denied by your carrier will become your responsibility.

Our office will file insurance claims for you, however, office visit co pays and deductibles are payable on the day you are seen. Please remember that you are responsible for all fees, regardless of insurance coverage. Some insurance plans require prior authorization. **This is your responsibility**. If we do not receive the authorization in advance, payment is due at the time of service. With your cooperation, you should be able to receive all benefits offered by your insurance plan, and we will be able to concentrate on caring for your medical needs.

AUTHORIZATION – PLEASE INITIAL & SIGN BELOW

______ I understand HIPAA and its policies.

______ I have read and understand the office policy stated above and agree to accept responsibility as described.

______ I authorize the release of medical information necessary to process a claim, to health care professionals requesting consultation, and third party payers responsible for payment of medical and surgical benefits to Robinson Facial Plastic Surgery.

Signature: ____ Date: _____________________

ROBINSON FACIAL
PLASTIC SURGERY
Burke Robinson M.D.

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient's Name: ____ DOB:__________________
(please print clearly)

Address: ____

____

Telephone Number: __________________________ (Home /Cell/ Office)

__________________________ (Home/Cell/ Office)

I give consent to be contacted at the following email address:

____@___________

☐ Sign up for our monthly newsletter. You can unsubscribe at any time.

CHECK ONE OF THE FOLLOWING:

______ When making contact by telephone, please make reasonable efforts to speak only to me.

______ When making contact by telephone, you may speak with anyone who answers.

______ When making contact by telephone, please make reasonable efforts to speak to me or the following person(s):

____

____

I understand that "reasonable efforts" means the staff of Robinson Facial Plastic Surgery, will ask the name of the person who answers the telephone and will, under reasonable circumstances, assume that the person is telling the truth. I further understand that if any additional costs are incurred by Robinson Facial Plastic Surgery in communicating with me as described above, I must make arrangements to pay those costs before Robinson Facial Plastic Surgery is obligated to communicate as I have requested.

____ ___________________________________

Signature **Date**

ROBINSON FACIAL
PLASTIC SURGERY

Burke Robinson M.D.

FINANCIAL RESPONSIBILITY

Date: __________________

Patient Name:____
(please print)

We are pleased to have you as a patient and will be happy to provide you services as long as you understand and agree to accept responsibility to our financial policy as described below.

All services provided by Dr. Burke Robinson and by his staff, as well as all products are billable and all payments are due at the time of service, with no exceptions. If you are uncertain of the price of a service, it is the patient’s responsibility, therefore your responsibility, to ask and to be prepared to make a payment in full.

I have read and understand the office policy stated above and agree to accept responsibility as described.

____ ______________________________

Patient Signature **Date**

ALPHARETTA OFFICE: 3400 Old Milton Parkway | Building C, Suite 330 | Alpharetta, GA 30005
ATLANTA OFFICE: 5555 Peachtree Dunwoody Road | Suite 155 | Atlanta, GA 30342
PH: 770.667.3090 | FAX: 678.867.0929 | www.ROBINSONFPS.com

APPOINTMENT CANCELLATION POLICY

Patient's Name: ____ DOB: ________________________

Dear Patient,

In order to continue to effectively and efficiently provide proper medical care to you, we have developed an appointment system that sets aside ample time for each patient. Late cancellations and "no-show" appointments inconvenience other individuals who desire access to medical care in a timely manner. If you do not show up for your scheduled appointment or notify us less than 48 hours in advance of your inability to keep your appointment, we are unable to efficiently reallocate your time to another patient, and therefore the time is lost to our office. In an effort to reduce the number of such occurrences, we have implemented an Appointment Cancellation Policy which is effective immediately.

Our policy is as follows:

1. We request you give our office 48 hours advance notice if you need to reschedule or cancel your appointment. You may contact us by calling or via the automated appointment reminder system sent to you by text to your phone on record.

2. If you miss your appointment or do not give at least 48 hours advance notice of needing to change or cancel your appointment, a $50.00 fee deposit secured with a credit card will be required for future appointments.

3. Future appointments resulting in late cancellations as described above and/or "no-show" will result in you forfeiting the deposit.

4. As a courtesy to all of our patients, our office has an automated reminder system in place. All of our patients will be notified of their scheduled appointment time via text, e-mail and phone call. However, the cancellation policy remains in effect regardless if a reminder message was received. It is ultimately the patient's responsibility to remember their scheduled appointments.

We appreciate your understanding in our attempt to assure you that your desire for timely and reliable appointments is maintained, should you have any questions or concerns, please let us know and we will be happy to clarify them for you.

I have read and understand the Appointment Cancellation Policy and agree to the terms of this policy.

____ ___________________________

Patient Signature Date

____

Printed Name

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