Dr. John A. Kotis
Board Certified Plastic Surgeon

PATIENT REGISTRATION

Patient

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Other Phone: (___) _____

Email: _____ Restrictions for contacting you? _____ yes _____ no

Contact Restrictions: (Specify) _____

Age: _____ Birth Date: _____ Height: _____ Weight: _____ Gender: M / F

Social Security Number: _____ Driver's License Number: _____

Marital Status: _____ Single _____ Married _____ Other Spouse/Partner's Name: _____

Patient's Employer/School: _____ Occupation: _____ Full/Part Time

Work Phone: (___) _____ Ext. _____ Is it okay to call you at work? _____ yes _____ no

Work Address: _____ City: _____ State: _____ Zip: _____

How did you hear about us? _____

Emergency Contact

Name: _____ Relationship to patient: _____

Emergency Contact Address: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Other Phone: (___) _____

Primary Insurance

Name: _____ Policy #: _____ Group ID : _____

Policy Holder's Name : _____ SSN #: _____ Insured's DOB: _____

Assignment and Release

I, _____, have insurance coverage and assign directly to Dr. Kotis all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Kotis, and/or all representatives there to release all information necessary to secure the payment of benefits and to file an appeal and seek claim status information. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Areas of Interest: (check all that apply)

Facial Procedures:

- ❒ Blepharoplasty (Eyelid Lift)
- ❒ Brow or Forehead Lift
- ❒ Cheek Implant
- ❒ Chin Augmentation
- ❒ Face or Neck Lift
- ❒ Facial Liposuction
- ❒ Lip Augmentation
- ❒ Otoplasty (Ear Surgery)
- ❒ Rhinoplasty/Septoplasty

Breast Procedures:

- ❒ Breast Augmentation
- ❒ Breast Implant Revision
- ❒ Breast Reconstruction
- ❒ Breast Reduction
- ❒ Male Breast Reduction
- ❒ Mastopexy (Breast Lift)
- ❒ Nipple Reduction/Inversion

Body Procedures:

- ❒ Abdominoplasty
- ❒ Brachioplasty (Arm Lift)
- ❒ Brazilian Butt Lift
  Buttock Augmentation
- ❒ Full Body Lift
- ❒ Liposuction/Body Contouring
- ❒ Scar Revision
- ❒ Thigh Lift
- ❒ Tummy Tuck/Correction of Tummy Tuck

In Office:

- ❒ Botox/Dysport
- ❒ Collagen
- ❒ Juvederm
- ❒ Latisse
- ❒ Lesions/Moles
- ❒ Prevelle/Hydrelle
- ❒ Radiesse
- ❒ Restylane/Perlane
- ❒ Sculptra
- ❒ Skin Care
- ❒ Other:

Health Information

Heart Trouble	Yes	No	Glaucoma or Eye Problems	Yes	No
Heart Attack	Yes	No	Visual Disturbances	Yes	No
Heart Pain	Yes	No	Error in Refraction	Yes	No
Palpitation or Irregular Pulse	Yes	No	Other Eye Problems	Yes	No
Extra Heart Beats	Yes	No	Hepatitis	Yes	No
Stroke	Yes	No	Yellow Jaundice	Yes	No
Hypertension	Yes	No	Gallstones or Gallbladder Trouble	Yes	No
Blood Pressure Abnormalities	Yes	No	Cirrhosis of the Liver	Yes	No
Abnormal EKG	Yes	No	Alcoholism or Drug Dependency	Yes	No
Rheumatic Fever	Yes	No	Esophageal Varices	Yes	No
Dropsy or Heart Failure	Yes	No	Frequent Indigestion	Yes	No
Digitalis Treatment	Yes	No	Ulcers	Yes	No
Shortness of Breath	Yes	No	Gastritis	Yes	No
Chest Pain	Yes	No	Colitis	Yes	No
Asthma	Yes	No	Problem Constipation	Yes	No
Bronchitis	Yes	No	Vomiting Blood	Yes	No
Pneumonia	Yes	No	Tarry or Bloody Bowel Movements	Yes	No
Tuberculosis	Yes	No	Hemorrhoids	Yes	No
Smokers Cough	Yes	No	Goiter or Thyroid Disorders	Yes	No
Emphysema	Yes	No	Diabetes	Yes	No
Coughing or Spitting of Blood	Yes	No	Skin Disorders	Yes	No
Hay Fever	Yes	No	Arthritis	Yes	No
Major Allergies	Yes	No	Fracture of Neck or Spine	Yes	No
Palsy or Paralysis	Yes	No	Bleeding Tendency or Disorder	Yes	No
Nervous Breakdown	Yes	No	Abnormal Bleeding after Tooth Extraction	Yes	No
Nervous Disorder	Yes	No	Airway Obstruction (Nasal)	Yes	No
Insomnia	Yes	No	Breast Cysts, Tumors, Abscesses	Yes	No
Drug Habit	Yes	No	Nipple Discharge (Apart from Normal Lactation)	Yes	No
Self-Destructive Tendencies	Yes	No	Kidney Disorder	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Blood Transfusion	Yes	No
Thyroid Problems	Yes	No	Seizures, Convulsions or Fainting Spells	Yes	No
Kidney or Renal Disease	Yes	No	Black Outs	Yes	No
Heart Murmur	Yes	No	Dentures, Bridges, Capped Teeth or Crowns	Yes	No
Piercing other than the ears	Yes	No	Loose Teeth	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No	Cosmetic bonding to teeth	Yes	No
Missed or Irregular last menstrual period	Yes	No	Any family members with bleeding problems	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No	Any family members with anesthesia problems	Yes	No

1. **Please list all present medications,** including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

_____

_____

2. Do you have an allergic reaction to any medication? ❒ Yes ❒ No Which? _____
3. Do you react abnormally to any medication? ❒ Yes ❒ No Which? _____
4. Have you, or any member of you family, ever had any difficulties with any medications, drugs or gases used for anesthesia?

   ❒ Yes ❒ No If yes, when and where? _____
5. Have you ever been on cortisone or steroid treatment? ❒ Yes ❒ No When? _____
6. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

   ❒ Yes ❒ No If so, how much? _____
7. Do you smoke? ❒ Yes ❒ No If so, what? _____ Frequency? _____
8. Are you pregnant? ❒ Yes ❒ No When was your last normal menstrual period? _____
9. How many pregnancies? _____ Births? _____ Breast Fed? ❒ Yes ❒ No How long? _____
10. Do you take Aspirin or Aspirin-like products? _____

    _____
11. When was your last physical exam? _____ By whom? _____
12. When was your last eye examination? _____ By whom? _____
13. Who is your personal physician, if any? _____

    _____
14. Have you ever been under psychiatric care? ❒ Yes ❒ No When? _____ Why?
15. Have you had any recent blood work done? ❒ Yes ❒ No Where? _____
16. Do you know anyone who has under the procedure you are interested in? ❒ Yes ❒ No
17. Have you done any reading about the procedure you are interested in? ❒ Yes ❒ No
18. Have you ever had a plastic surgery procedure before? ❒ Yes ❒ No
19. Is there anything else you think the doctor should know?

    _____

    _____

    _____

20. Please list all hospitalizations and surgeries, including procedures done for cosmetic reason:

SURGICAL OPERATIONS (include where, when, why and complications for each surgery & anesthesia complications):

HOSPITALIZATIONS (include where, when and why for each admission):

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to use or disclosure of my projected health information by Dr. Kotis for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Dr Kotis. I understand that diagnosis or treatment of me by Dr. John Kotis may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Dr. Kotis is not required to agree to the restrictions that I may request. However, if Dr. Kotis agrees to a restriction that I request, the restriction is binding on Dr. Kotis.

I have the right to revoke this consent in writing, at any time, except to the extent that Dr. John Kotis has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and indentifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Dr. Kotis's Notice of Privacy Practices prior to signing this document. Dr Kotis's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Kotis. The Notice of Privacy Practices for Dr. Kotis is also provided in the office and on Dr. John Kotis's website at **www.drkotis.com**. This Notice of Privacy Practices also describes my rights and Dr. Kotis's duties with respect to my protected health information.

Dr. Kotis reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Dr. Kotis's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

By signing below, I agree to the aforementioned information and attest to the accuracy and completeness of the information I provided.

Signature: _____ Date: _____

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Appointment Cancellation Policy

Each client is provided with customized service and treatment by Dr. John Kotis. As such, we reserve 60-90 minutes per client appointment to ensure adequate treatment time and a personalized consultation. Please note that we require at least a 24-hour advanced notification for any changes or cancellations to your appointment. Without such advanced notice, your credit card will be charged with $75.00.

Dr. Kotis appreciates your patronage, and thanks you in advance for your understanding.

_____ _____

Client Name and Signature Date