JANDALI PLASTIC SURGERY

New Patient Consultation Form
Hair Removal, Skin Tightening, and Intense Pulse Light (IPL)

Name: First________________________________Middle_____________Last_______________________________

Address:____

City____________________________________ State ____________ Zip Code ______________

Home Phone #(____)_______-_________ Work #(____)_________-_________ Cell #(____)________-___________

Emergency # (____)_______-_______ Emergency Contact Name _____________________ Relationship __________

Social Security Number______-______-______ Date of Birth______/______/_____ Age: _______ □ Male □ Female

E-mail Address ________________________________@___________________

Who is your primary care physician? _____________________________________ Phone: (____) _______-_______
(If you go to a group please specify the name of the physician you see most often.)

Your privacy is of the utmost importance to us. Please indicate below if there are any restrictions in contacting you:
____

PHARMACY INFORMATION

As of January 1, 2018 the State of Connecticut is going to an e-prescribe system for all prescriptions.

Preferred Pharmacy Name: _________________________ Address: __________________________ Phone: ___________

HOW DID YOU HEAR ABOUT OUR PRACTICE?

____A Physician Name: ____________________________________ Phone: _____________________
____Family Member/Friend Name:____
____Newspaper/Television Which publication/program____
____Seminar Date & Topic? ____
____Internet Website:____
____Other Please explain____

Name____________________________________

PATIENT HISTORY FORM

Do you have any medical problems:____
____
____

Circle if you have any of the following:
Thyroid disease Bleeding disorder Pacemaker or defibrillator Pigmentation disorder

Photoallergies Skin cancer Diabetes Polycystic ovarian disease

What surgeries have you had and when:____
____
____

Medications: (please list dosage and # of times taken daily; include over the counter and herbals remedies)
____
____
____
____

Are you currently taking any Antibiotics?____

Allergies: (which medications and what happens)____
____

Personal Social History: (please circle or fill in)
Do you smoke? Yes No How much and for how long?_______________________________________

If you used to smoke but quit, how much, for how long, and when did you quit?______________________________

Do you drink alcohol? Yes No How much and how often?____

Do you take aspirin, Advil, or fish oil daily? Yes No

WOMEN: Are you Pregnant, Trying to get Pregnant, or Lactating (nursing)? __________________________

Are you currently using or have you ever used Retin-A? Yes No
If yes, when started? _________________________ Stopped when? ________________________

Are you currently using or have you ever used Accutane? Yes No
If yes, when started? _________________________ Stopped when? ________________________

Do you have any skin disorders? Yes No
If yes, please explain: ____

Do you have or have you ever had vitiligo (loss of skin pigment)? Yes No

Are you a keloid former (thick scars)? Yes No

Do you ever get “herpes” skin eruptions or cold sores? Yes No

AUTHORIZATION FOR AND RELEASE OF
MEDICAL PHOTOGRAPHS AND/OR VIDEO FOOTAGE

Name ____

I consent to the taking of photos, slides, or video footage by Dr. Shareef Jandali or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Shareef Jandali.

I provide this authorization as a voluntary contribution for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, websites, magazines, newspapers, media reports, medical journals, and textbooks, for the purpose of advertising or informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Shareef Jandali.

I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any affect on any actions taken prior to my revocation and I do hereby release Dr. Shareef Jandali, his agents and employees from all liability in connection with said actions.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge Dr. Shareef Jandali and all parties acting under his license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_________________________________ _________________________________
Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of ________________________ _______, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_________________________________ _________________________________
Signature Date

Jandali Plastic Surgery

CONSENT FOR COMMUNICATION via E-MAIL or TEXT

I hereby consent to have Dr. Shareef Jandali communicate, where appropriate, with me or members of his staff, other physicians, nurse practitioners, physician assistants, billing services, and insurance carriers, via e-mailing or text messaging regarding aspects of my medical care and treatment. I understand that e-mail and text are not a completely confidential method of communication. I further understand that there is a risk that e-mail or text communications between my physician and others (listed above) regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. Our practice will take utmost care in protecting personal health information, but this form of communication is often necessary to maintain close patient care. I understand that in an urgent or emergent situation, I should call my provider or go to the Emergency Room and not rely on email and/or text messaging.

Patient Name: ________________________________

Patient's Signature_________________________________ Date___________

AUTHORIZATION FORM FOR PATIENT RECORDS RELEASE

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that my patient information may be subject to re-disclosure by the authorized recipients of the information listed below and that my information may no longer be protected by federal privacy regulations once it is disclosed.

Patient Name: ________________________________

Patient's Signature_________________________________ Date___________

Persons/entities authorized to receive my patient information:

________________________________ Name	__________________________ Relationship
________________________________ Name	__________________________ Relationship
________________________________ Name	__________________________ Relationship

Specific description of the information to be used or disclosed (including date(s) if applicable):

____

____

____

Skin Type Assessment

Patient Name: ____ Date:______________

Ethnicity/Race____________________
Nationality____________________

Score		0	1	2	3	4
	What is the color of your eyes?	Light Blue, Gray, Green	Blue, Gray, Green	Blue	Dark Brown	Brownish Black
	What is the natural color of your hair?	Sandy Red	Blond	Chestnut, Dark Blond	Dark Brown	Black
	What is the color of your skin (unexposed areas)?	Very Pale	Pale	Pale with Beige Tint	Light Brown	Dark Brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful Redness, Blistering	Blistering followed by Peeling	Burn, sometimes followed by Peeling	Rarely Burn	Never Burn
	To what degree do you turn brown?	Hardly, Not At All	Light Color Tan	Reasonable Tan	Tan Very Easily	Turn Dark Brown Quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very Sensitive	Sensitive	Normal	Very Resistant	Never Had a Problem
	When did you last expose yourself to the sun, tanning bed, or tanning creams?	More than 3 Months Ago	2-3 Months Ago	1-2 Months Ago	Less than 1 Month Ago	Less than 2 Weeks Ago
	Do you expose the areas to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always

Total Score: __________

Score:	**Fitzpatrick Skin Type**
0-7	**I**
8-16	**II**
17-26	**III**
26-30	**IV**
Over 30	**V-VI**

SKIN TYPE

TYPE	**BASELINE SKIN COLOR**	**REACTION TO SUN**
I	White	Always burn, never tan
II	White	Usually burn, tan with difficulty
III	White	Sometimes mild burn, tan gradually
IV	Olive	Rarely burn, tan well
V	Dark brown	Rarely burn, tan darkly
VI	Black	Never burn, tan darkly black

Precautions to Laser/IPL/Radiofrequency Treatments

Please check box if you have any of the following risk factors:
□ Medications that cause photosensitivity (see next page)
□ Facial laser resurfacing or deep chemical peeling to the planned treatment area in the last 3 months
□ Healing disorders or impaired healing
□ History of skin cancer in the treatment area or family history of melanoma
□ Allergy to Nickel (part of the laser electrode is nickel plated)
□ Herpes I or II in the area to be treated
□ Thyroid disease currently not medicated

Contraindications to Laser/IPL/Radiofrequency Treatments

Please check box if you have any of the following:
□ Chemotherapy or related medications (i.e. Tamoxifen)
□ Atypical or premalignant moles, skin cancer – on the planned treatment area
□ History of bleeding disorders
□ Pacemaker or defibrillator
□ Cardiac disorders
□ Impaired immune system
□ Superficial implants, teeth implants, Invisalign
□ Seizures or diseases stimulated by light: Epilepsy, Lupus, Porphyria
□ Multiple Sclerosis
□ Anticoagulants: Coumadin, Warfarin, Plavix, Aspirin, Aleve, Motrin, Advil, Ibuprofen
□ Steroid use (i.e. Prednisone)
□ Current antibiotic use: see next page
□ Accutane taken within the last year
□ History of hypertrophic or keloid scarring
□ Non-intact skin in the treatment area: sores, psoriasis, eczema, infection, rash, open wounds
□ Diabetes
□ Pregnancy
□ Tattoos or permanent makeup in the treatment area
□ Recent use of depilatory creams or sprays, bleaching medications
□ Sunburn to the treatment area
□ Suntan, real or fake, on the treatment area
□ Photo-sensitizing topical creams or medication: see next page

I certify that I have provided truthful information to the best of my knowledge, that I have been given the opportunity to ask questions, and that I have read and fully understand the contents of this consultation form. I am aware of the potential for a burn or scar with any procedure.

Patient Name (printed): ______________________ Patient Signature: ______________________ Date: __________