PRESTIGE
COSMETIC SURGERY

NEW PATIENT INFORMATION

Confidential Information: *The information provided will only be used by Prestige Cosmetic Surgery unless permission is granted by the patient or guardian.*

Today's Date _____

Patient's Name_____

Parent or Guardian's Name (for minors) : _____

Address_____

City _____ State _____ **Zip**_____

Telephone Numbers **Home** _____ **Work** _____

Cell Phone _____ May we contact you through text message? ☐ Y ☐ N

E-mail Address _____

May we contact you via e-mail regarding promotions and monthly specials? ☐ Y ☐ N

Preferred method for clinic to contact you: ☐ Home ☐ Work ☐ Cell Phone ☐ E-mail

Date of Birth_____ **Age** _____ **Height** _____ **Weight** _____

Gender ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Other

Occupation: _____

Social Security Number: _____

Emergency Contact Name_____

Telephone **Home** _____ **Cellular**_____ **Work** _____

Preferred Pharmacy (Name and Phone Number):

_____

What concerns would you like to discuss during your appointment?

_____

_____

_____

_____

_____

Have you had any previous treatment for this?

_____

_____

_____

Review of Systems

Do you have or have you had any of the following?

Please check all that apply.

- ☐ AIDS or HIV positive
- ☐ Hepatitis
- ☐ Anemia
- ☐ High blood pressure
- ☐ Arthritis
- ☐ Irregular heart beat
- ☐ Kidney problems
- ☐ Shortness of breath with exercise
- ☐ Chronic headaches
- ☐ Blood clots in legs
- ☐ Nervous breakdown
- ☐ Blood disorders
- ☐ Nose/throat problems
- ☐ Bleeding problems
- ☐ Breathing problems
- ☐ Psychiatric condition
- ☐ Cancer
- ☐ Rheumatic fever
- ☐ Chest pains
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Skin cancer
- ☐ Ear/eye problems
- ☐ Thyroid problems
- ☐ Stroke
- ☐ Heart problems
- ☐ Chest pain with exercise
- ☐ Tuberculosis
- ☐ Heart palpitations
- ☐ History of Transfusion

Please explain any conditions checked above.

_____

_____

_____

_____

_____

_____

PRESTIGE
COSMETIC SURGERY

List all current and past medical problems.

List any previous surgeries with dates.

Please list all current medications to include those which do not require a prescription.

List all allergies to medications

Social History

Do you currently smoke? ☐ Yes ☐ No

If yes, how many packs per day? _____

How many years? _____

Have you ever smoked? ☐ Yes ☐ No

If yes, how many packs per day? _____

How many years? _____

PRESTIGE
COSMETIC SURGERY

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much? _____

How often? _____

List any hospitalizations including dates:

_____

_____

_____

Do you have any relatives who have had breast cancer? ☐ Yes ☐ No

If yes, who?

_____

_____

Have you ever had a mammogram? ☐ Yes ☐ No
If yes, when was your last one? _____
Have you had an abnormal mammogram? ☐ Yes ☐ No

How did you learn about us? *(Please check all statements that apply.)*

☐ Friend/ Past Patient _____

☐ Doctor _____

☐ Website

☐ Tricare Referral

☐ Location is convenient to my home or office.

☐ Other _____

☐ Newspaper; which one? _____

PRESTIGE
COSMETIC SURGERY

18707 Hardy Oak Blvd Suite 455
San Antonio, TX 78258
Phone (210) 255-1764
Fax (210) 255-8891

Patient Consent for Use of Medical Imagery

Patient Name: _____ Date: _____

I Consent for Medical Imagery (still photographs, video and/or audio recordings) to be made of:

Self _____ my child _____ (or) Person for whom I am legal guardian of_____

I understand that the information may be used in my medical records, for purposes of medical teaching, medical boards/examinations, for publication in medical textbooks, journals or **Prestige Cosmetic Surgery P.A. web site** as I have designated below. By consenting to this, I understand that the imagery may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although the imagery will be used without identifying information, I understand that it is possible that someone may recognize me, or the person for whom I am legal guardian. I understand that I will not receive payment from any party. If I have any questions or wish to withdraw my consent in the future I may contact: **Dr. Bernard Kopchinski with Prestige Cosmetic Surgery P.A.**

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

PLEASE CHOOSE ONE:

1) I consent for the imagery to be used in my medical records or the medical records of my child or the person for whom I am legal guardian, for teaching purposes, medical publications including medical journals, textbooks, medical boards/examinations **AND** electronic publications (**Prestige Cosmetic Surgery P.A. web site**).

_____ (Signature)

_____ (Witness)

2) I consent for the imagery to be used in my medical records or the medical records of my child or the person for whom I am legal guardian, for teaching purposes, medical publications including medical journals, textbooks, and medical boards/examinations but **NOT FOR** electronic publications (**Prestige Cosmetic Surgery P.A. web site**).

_____ (Signature)

_____ (Witness)

PRESTIGE
COSMETIC SURGERY

Acknowledgement of Notice of Privacy Practices

I, _____, hereby acknowledge that I have been offered a copy of Prestige Cosmetic Surgery's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Name Date

_____ _____

Witness Date