

# PLASTIC SURGERY PAVILION

**JAMES APESOS, M.D., F.A.C.S.**

**CERTIFIED**  
Certified American Board of Plastic Surgery  
Certified American Board of Surgery  
Certified Hand Surgery

Cosmetic Surgery  
Hair Restoration  
Skin Care

## PATIENT REGISTRATION FORM

(PLEASE PRINT CLEARLY)

Patient's Name \_\_\_\_\_

Social Security # \_\_\_\_\_

Address \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

( \_\_\_\_\_ ) \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_

Occupation \_\_\_\_\_

( \_\_\_\_\_ ) \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_

Email \_\_\_\_\_

\*I give James Apesos MD permission to notify me of sales, events, & treatments\*

## RESPONSIBLE PARTY INFORMATION

Name \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## REFERRING PERSON

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

I agree to release photographs, preoperative, intraoperative, and postoperative, as needed by James Apesos, M.D., and relenquish all rights to publications, presentations, and medical use of my photographs, including face, as needed by James Apesos, M.D. for medical education and promotional publication.

Medical photographs are utilized in plastic surgery as are x-rays and cardiograms in medicine.

**Such records are kept and provided as reference points for past and future treatment in plastic surgery for James Apesos, M.D.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

{OVER}

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## 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 acknowledge that I have received 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.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

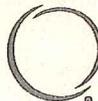
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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	Initials	Reason



Member

AMERICAN SOCIETY OF PLASTIC SURGEONS, INC.  
AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY

**PATIENT MEDICAL HISTORY – DR. APESOS**

Name \_\_\_\_\_ Age \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

**ALLERGIES**     LATEX     No know drug allergies     Food     Other  
 List \_\_\_\_\_

**PERSONAL HEALTH HISTORY** (Check all that apply)

Heart problems     Heart attack     Chest pain     Heart failure     Irregular heart beat

Internal defibrillator     Rheumatic fever     Mitral valve prolapse     Pacemaker

Comments \_\_\_\_\_

Lung problems     Asthma     Emphysema     TB     Chronic lung disease     Shortness of breath

Comments \_\_\_\_\_

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Radiation therapy    | <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Emotional problems      |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bleeding problems    | <input type="checkbox"/> HIV            | <input type="checkbox"/> Thyroid problems        |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Stomach problems     | <input type="checkbox"/> Chicken pox    | <input type="checkbox"/> Kidney/bladder problems |
| <input type="checkbox"/> Chemotherapy        | <input type="checkbox"/> Other _____          |   |  |

Comments: \_\_\_\_\_

LMP \_\_\_\_\_ Pregnancy \_\_\_\_\_ Childbirth \_\_\_\_\_

Previous surgeries with dates \_\_\_\_\_

Complications to anesthesia?     Yes     No    Explain \_\_\_\_\_

Other hospitalization with dates \_\_\_\_\_

Family health history (Check all that apply)     High blood pressure     Stroke     Diabetes  
 Heart disease     Cancer (site) \_\_\_\_\_     Other \_\_\_\_\_

**Current Medications**

For additional medications, please use page 2

DRUG NAME	DOSAGE	TIMES PER DAY

Do you take anything else by mouth? (i.e., herbals, dietary supplements, vitamins, antacids, pain relievers, recreational drugs, etc.)

NAME	DOSAGE	TIMES PER DAY

Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Stopped	Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No	History of addiction <input type="checkbox"/> Yes <input type="checkbox"/> No
Length of time used:	Frequency of use:	Explain:

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Specialist(s) \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Phone # \_\_\_\_\_

Reason for consultation \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Reviewed By \_\_\_\_\_ Date \_\_\_\_\_

JAMES APESOS MD PATIENT PRIVACY QUESTIONNAIRE

RELEASE OF MEDICAL INFORMATION

I give my permission to release confidential health information to the following people.

<u>Name</u>	<u>Relationship to Patient</u>	<u>For Verification Purposes, Date of Birth</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

*\*\*\*Please specify if there is any personal health information you do NOT want to be disclosed to the above named people\*\*\**

TELEPHONE CONTACT

Is it OK to contact you at work? Yes or No Telephone# \_\_\_\_\_

Is it OK to contact you at home? Yes or No Home# \_\_\_\_\_

Is it OK to leave a brief message on your answering machine? Yes or No

Is it OK to leave a message with the person answering the telephone? Yes or No

If you are available by pager or cell phone, list the numbers below:

Pager# \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Notes \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Notify the office in writing of your request to change or update any of the above information.

# NOTICE

## James Apesos MD Inc and The Skin Health Center

The cancellation Policy for all James Apesos MD Inc and The Skin Health Centers patients is as follows:

We understand your life is busy and an occasional lapse of memory is inevitable. For this reason, we will excuse the first missed appointment (cancellations with less than 24 hours notice as well as 'no shows') but future appointments will need to be guaranteed with a deposit. A \$50 deposit will be required for all Consultations, Pre and Post Operative appointments and Skin Care Treatment appointments. A \$100 deposit will be required for all Botox, Sclerotherapy, Dermal Filler, CoolSculpt and Microneedling appointments. Upon the first missed appointment, the letter below will be mailed to your home informing you of our intentions.

Thank you, in advance, for your cooperation.



James Apesos M.D.

Sample letter:

*This is to inform you that you have missed, or failed to give adequate notice, for your scheduled appointment on \_\_\_\_\_ for \_\_\_\_\_. As a courtesy to other patients and our staff, we require a cancellation notice of at least 24 hours for all appointments. To give 24 hours notice for Monday appointments, please call Friday before 5 p.m. Future consultations, pre and post operative appointments and skin care treatments will need to be guaranteed with a \$50.00 deposit & all other appointments will need to be guaranteed with a \$100.00 deposit before scheduling. This deposit will be deducted from your total fee the day of your procedure or may be carried over towards your next procedure. Cancellations received less than 24 hours will forfeit their deposit. Please understand that you are very important to us and we value your association with James Apesos MD Inc and The Skin Care Center. We are simply trying to ensure that our staff is used to its fullest extent, in order to provide service to the greatest number of people.*

*Thank you for your cooperation.*

*Sincerely,*

**Patient Signature** \_\_\_\_\_  
**Date** \_\_\_\_\_