EASTERN SHORE
COSMETIC SURGERY
James Koehler, MD

Please make every effort to fill out the information fully and accurately so we can provide the best care.

Your responses are held strictly confidential and not shared.

Name:_____ **Date of Birth** ____/____/_____ **Age**:_____ **Sex**: M F

Height:_____ Weight:_____ Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Mail Address _____City_____State_____Zip_____

Home Phone:_____ Cell Phone:_____ Work Phone_____

Email:_____ SS#_____

Preferred Method(s) of Contact: ❑ Home phone ❑ Cell phone ❑ Work phone ❑ Email

Where Employed: _____ Occupation:_____

In Case of Emergency, Contact: _____

Relationship:_____ Phone:_____

Please Check The Procedures You Wish To Discuss With Dr. Koehler:

Non- Surgical	Face	Breast	Body
❑ Latisse Eyelash Growth	❑ Eyelid Surgery	❑ Breast Augmentation	❑ Liposuction
❑ Botox	❑ Ear Pinning	❑ Breast Implant Exchange	❑ Tummy Tuck
❑ Wrinkle Filler	❑ Nose Surgery	❑ Breast Implant Correction	❑ Belt Lipectomy
❑ Lip Enhancement	❑ Brow Lift	❑ Breast Lift	❑ Arm Reduction
❑ Skin Care	❑ Neck Lift	❑ Breast Reduction	❑ Brazilian Butt Lift
❑ Obagi Blue Peel	❑ Full Face Lift	❑ Correction of Asymmetry	
		❑ Male Breast Reduction	

Please use this space to provide any other information that you feel may be helpful to your consultation:

_____

_____

_____

Why did you choose Dr. Koehler? Please indicate all that apply

❑ Friend Referral May we ask who? _____

❑ Doctor Referral May we ask who? _____

❑ General Reputation or Recommendation

❑ Website

❑ Facebook

❑ Newspaper _____

❑ Radio

❑ Magazine _____

❑ Other _____

Do You Have or Have You Had? (If yes, give date of occurrence)

Arthritis	No	Yes _____	Congenital Heart	No	Yes _____	Leukemia	No	Yes _____
Asthma	No	Yes _____	Diabetes	No	Yes _____	Migraine	No	Yes _____
AIDS or HIV	No	Yes _____	Epilepsy	No	Yes _____	Nervous Breakdown	No	Yes _____
Back Problems	No	Yes _____	Goiter	No	Yes _____	Pneumonia	No	Yes _____
Bladder Infection	No	Yes _____	Hay Fever	No	Yes _____	Rheumatic Heart	No	Yes _____
Bleeding Tendency	No	Yes _____	Heart Attack	No	Yes _____	Stomach Ulcers	No	Yes _____
Bronchitis	No	Yes _____	Hepatitis	No	Yes _____	Stroke	No	Yes _____
Cancer	No	Yes _____	High Blood Pressure	No	Yes _____	Tonsillitis	No	Yes _____
Colitis	No	Yes _____	Kidney Disease	No	Yes _____	Tuberculosis	No	Yes _____

List any Serious ILLNESSES that you have had in the past that are not included in the above list:

_____
_____
_____

List any OPERATIONS you have had (including plastic surgery) Give approximate dates:_____

_____
_____
_____

List ALL MEDICATIONS you take:_____

_____
_____
_____

Are you **ALLERGIC** to ANY medications? No Yes (please list)

_____
_____
_____

Do you smoke? ❑ ***No*** ❑ ***Yes*** How much? _____

Do you use nicotine of any kind? (Vapor, Gum, Chewing Tobacco) ❑ ***No*** ❑ ***Yes*** How much?_____

Are you a former smoker? ❑ ***No*** ❑ ***Yes*** When did you quit? _____

Do you drink alcohol? ❑ ***No*** ❑ ***Yes:*** ❑ Occasional ❑ 1-2 Drinks daily ❑ 3 or more drinks daily

Do you use any Recreational Drugs?

❑ ***No*** ❑ ***Yes*** What?_____ Times a week?_____ How many years?_____

Do you or have you ever had an addiction to narcotics or recreational drugs?

❑ ***No*** ❑ ***Yes*** What?_____ Times a week?_____ How many years?_____

Do you take diet pills? ❑ ***No*** ❑ ***Yes*** (list): _____

Do you take HERBAL supplements? ❑ ***No*** ❑ ***Yes*** (list): _____

Do you have a LATEX ALLERGY? ❑ ***No*** ❑ ***Yes*** Any other contact allergy? (eg. surgical tape)list: _____

Have you had any complications from anesthesia? ❑ ***No*** ❑ ***Yes*** (if yes, explain):_____

Please review the list and check anything that applies to you. Use the space below for any explanations:

☐ Severe dryness of the eyes	☐ Menstrual disorder	☐ Shortness of breath
☐ Recurrent severe dizziness	☐ Problems with bones or joints	☐ Heart disease or High blood pressure
☐ Chronic sinus problems or nasal blockage	☐ Cancer	☐ Kidney or bladder problems
☐ Paralysis of the face	☐ Chronic skin condition	☐ Blood in urine or trouble urinating
☐ Chronic hoarseness	☐ Asthma or Emphysema	☐ Easy bruising
☐ Chest pain	☐ Glaucoma or blurry vision	☐ Abnormal lump or node
☐ Chronic abdominal pain	☐ Severe headaches	☐ Unexplained weight loss
☐ Blood in bowel movements	☐ Recurrent fever blisters	☐ Emotional or psychological problems
☐ Bleeding disorders (you or anyone in your family)	☐ Bad surgical results or unsatisfactory medical care	☐ Complications after surgery

Please Explain:

_____
_____
_____
_____

Describe any **Major Injuries** you have sustained (include dates): _____
_____
_____
_____

Women ONLY:

Is there any chance you may be pregnant? ❑ ***No*** ❑ ***Yes***

How many pregnancies have you had? _____

How many children born alive? _____

How many cesarean operations? _____

Any complications with pregnancy? _____

Date of last breast exam: _____ Results: _____

Date of last mammogram: _____ Results:_____

Breast Cancer History: Do you have/had:

- ❑ 2 or more relatives with breast cancer
- ❑ Mother, sister or daughter with breast cancer
- ❑ A relative with breast cancer before the age of 50 _____
- ❑ A relative with both breast and ovarian cancer

I HAVE READ THIS FORM ENTIRELY AND HAVE COMPLETED IT FULLY AND ACCURATELY TO THE BEST OF MY KNOWLEDGE.

Date this form was completed: _____ Patient Signature: _____

Eastern Shore Cosmetic Surgery - James Koehler, MD

I _____ represent to the physician/providers and staff that I am at least 18 (eighteen) years of age or, if not, I am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor/provider and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payment of medical benefits directly to the doctor/provider for services provided to me. A copy of this authorization shall be considered as valid as the original. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of my surgeon/provider and under such conditions as may be approved by him/her. These photographs will be used soley for documentation purposes and will be kept confidential.

I agree I am responsible for all charges for goods and services rendered by Eastern Shore Cosmetic Surgery, PC including reasonable attorney's fees and cost of collection in the event of default.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

Signature: _____ Date:_____
Relationship: (Circle one) Patient Spouse Parent Guardian

HIPAA Patient Consent Form

I, _____understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); Obtaining payment from third party payers including insurance and credit card companies. This would include the minimum medical records necessary to complete any transaction. The day-to-day healthcare operations of this practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIIPPA. I understand that you reserve the right to change the terms of this notice form time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Release of Information

❑ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:
❑ Spouse_____
❑ Child(ren)_____
❑ Other_____
❑ Information is not to be released to anyone.
This Release of Information will remain in effect until terminated by me in writing.

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PATIENT CONTACT CONSENT

I authorize Eastern Shore Cosmetic Surgery, PC to call and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out my care, such as appointment reminders, insurance items, billing inquiries, any calls pertaining to my clinical care including laboratory results.

Please contact me by: ❑ my home ❑ my work ❑ my cell ❑ email
If unable to reach me:
❑ you may leave a detailed message
❑ please leave a message asking me to return your call

The best time to reach me is (day)_____ between (time)_____

With my consent all financial and medical information can be given to the following people:
(To obtain a copy of medical records, person must give a valid driver's license. To verify any information by a nurse/ medical assistant/office personnel, person must verify DOB and last 4 digits of patient's social security number)
Absolutely, NO medical records will be released without the above information.

Name:_____ Relationship _____ Phone _____

Name:_____ Relationship _____ Phone _____

Name:_____ Relationship _____ Phone _____

Name:_____ Relationship _____ Phone _____

With my consent all medical information can be given to the following doctors/medical personnel:

Name:_____ Relationship _____ Phone _____

Name:_____ Relationship _____ Phone _____

Patient Signature: _____ *Date:*_____

Guardian Signature: _____ *Date:*_____ *Relation to Patient:*_____

*Witness:*_____ *Date:*_____