**J Gonzalez, MD Aesthetic Surgery**
**F. Jorge Gonzalez, MD**

Nombre: ________________________________________ Inicial: ________ Apellido: _____________________________________

Direccion: ______________________________________________________________________________________________

Ciudad: __________________________________________ Estado: ________________ Codigo Postal: ___________________

Telefono Casa: _______________________________________ Telefono Celular: ________________________________________

Fecha de Nacimiento: ______________________ Edad: ___________ Sexo: ____________ SSN: _______________________

Correo Electronico: _____________________________________________________________________________________

Quien es su doctor primario y cuando fue su ultima visita? ____________________________________________

Farmacia de su preferencia (nombre y localidad): ___________________________________________________________
Como se entero de nosotros?

Paciente: ___________________________________________ Amigo(a): _________________________________________

Otro: ___________________________________________________________________________________________________

## Contacto de Emergencia

Nombre: __________________________________________________________ Relacion: _______________________________
Numero de Telefono: ____________________________________________________________________________________

## Consentimiento para comunicarnos: Marque las formas que usted desea ser contactado.

| Metodo | OK para dejar mensaje de voz? | OK para dejar mensaje con otra persona? | Escoja un metodo preferable de contactarnos. | Mejor hora para llamar |
|---|---|---|---|---|
| Llamar Telefono Casa | Si | Si | | ______________ |
| Llamar Telefono Celular | Si | Si | | ______________ |

Enviar Mensaje de texto. Compania de Celular: _______________________________________________________

Enviar Recordatorios de citas Enviar informacion medica/cirugia

Firma del Paciente: ______________________________________ Fecha: ______________

# Historial Medico

Nombre: ________________________________________ Fecha de Nacimiento: ___________________

## Seccion I: Historial de Cirugias y Anestesia

Ha tenido alguna cirugia en el pasado? No Si

Si, Mencione: ________________________________________________________________________________

Ha tenido algun accidente en el pasado? No Si

Si, Mencione: ________________________________________________________________________________

Usted o algun familiar ha tenido complicaciones con anesthesia en el pasado? No Si

Si, Describa: ______________________________________________________

## Seccion II: Historial Medico

Estatura: ___________ Peso: ____________ (Office Use Only) BMI: ____________

No / Si | No / Si

Ha sido diagnosticado con alguno de estos sintomas?

1. Anemia
2. Asma
3. Enfermedad Pulmonar
4. Tendencia de sangrar / Hemorragias
5. Coagulos
6. Cancer
7. Diabetes
8. Alta Presion
9. Enfermedades Cardiacas
10. Hepatitis
11. Herpes/Ulceras
12. Problemas de Higado o rinones
13. Epilepsia o Convulsiones
14. Depresion, Ansiedad, Psicosis
15. Ha tenido transfusion de sangre?
16. Bronquitis
17. Migrana
18. Enfermedad Periodontal
19. Derrame
20. Tiroides
21. Neumonia
22. Tuberculosis
23. Ulcera en el estomago
24. Problemas de Espalda
25. Leucemia
26. Positivo VIH
27. Le han recomendado o ha tenido cuidado psiquiatrico?
28. Ataque al corazon
29. Ha tomado esteroides?
30. Mencione otros: ______________________________________________________________________

## Seccion III: Historial Social

No / Si | Si, Cuanto?

1. Usted fuma? ____________________________
2. Consume bebidas alcoholicas? ____________________________
3. Ha aumentado o perdido peso recientemente? ____________________________

## Seccion IV: Historial Familiar

1. Si mama continua viva? No Si
   No, Mencione edad y la razon: ______________________________

2. Su papa continua vivo? No Si
   No, Mencione edad y la razon: ______________________________

3. Sus hermanos estan saludables? No Si
   No, Explique: ______________________________

4. Usted o algun familiar tiene historial de cancer de seno? No Si Si, Quien? ______________

## Seccion V: Medicamentos

1. Ha estado enfermo(a) recientemente? No Si Si, explique: ______________

Mencione todos los medicamentos, vitaminas, hierbas o suplementos dieteticos que este tomando:

| Nombre del Medicamento | Cantidad | Cuantas veces al dia? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Seccion VI: Alergias y sensibilidad a medicamentos

Mencione todas las alergias y/o sensibilidades: Marque aqui si no tiene ninguna alergia a medicamentos.

| **Alergia:** | **Gravedad:** | **Reaccion:** |
|---|---|---|
| | Mild Moderate Severe | |
| | Mild Moderate Severe | |
| | Mild Moderate Severe | |

1. Eres alergico a algun adhesive medico como cinta adhesiva, “steri-strip”, curitas, latex, o cualquier otro?
   No Si Si, mencione: ______________________________

## Seccion VII: Solo Mujeres

1. Dia de su ultima mamografia: ______________ 2. Numero de embarazos: ______________

3. Tiene auto-examenes de mama regularmente? No Si

4. Amamantas? No Si

5. Protuberancia mamaria o secrecion? No Si

6. Estas embarazada o estas intentando de quedar embarazada? No Si

7. Estas tomando pastillas anticonseptovas o alguna terapia de reemplazo de hormonas? No Si

**He leido este cuestionario y he relevado mi historial medico a mi mayor conocimiento.**

Patient Signature: ______________________________ Date: ______________

# Cuestionario

*Para estar seguros que el Dr. González conteste todas sus inquietudes de manera clara y detallada, Por favor tome un momento para responder estas preguntas.*

## Questions about your visit:

1. Describa las intervenciones de cirugía plástica que usted desea realizarse:
   ______________________________________________
2. ¿Desde hace cuánto tiempo desea operarse?
   ______________________________________________
3. ¿Ha consultado previamente a un otro cirujano plástico?
   ______________________________________________
4. ¿Le han realizado algún tipo de cirugía estética?
   ______________________________________________
5. ¿Porque ha elegido al Dr. González para realizar su cirugía?
   ______________________________________________

Mis metas de esta consulta incluyen hablar de:

1. ______________________________________________
2. ______________________________________________

Estoy considerando cirugía para:

1. Lo más pronto posible? Sí, cuando? ____________________
2. 1-3 meses de ahora? Sí, cuando? ____________________
3. 6-12 meses de ahora? Sí, cuando? ____________________
4. Solo busco información? ____________________

Estado de salud o factores que puedan afectar mi recuperación:

______________________________________________

¿Tiene un presupuesto en mente para su cirugía?

☐ Sí ☐ No Sí, cuánto sería? ____________________

Comentarios: ______________________________________________

# Consent for Purposes of Treatment, Payment And Healthcare Operations (HIPAA)

I, ________________________________, consent to the use or disclosure of my protected health information by **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez, MD)** for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez)**. I understand that diagnosis or treatment of me by **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez, MD)** 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 healthcare operations of the practice. **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez, MD)** is not required to agree to the restrictions that I may request. However, if **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)** agrees to a restriction that I request, the restriction is binding on **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez).**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD))** 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 healthcare provider, a medical insurance provider, or my employer. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I authorize **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)** to communicate with my physicians.

I understand I have a right to review **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)'s** "Notice of Privacy Practices" prior to signing this document. The **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices 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 healthcare operation of the **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)**. The Notice of Privacy Practices for **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)** is provided at **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD).**. This Notice of Privacy Practices also describes my rights and **J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)'s** duties with respect to my protected health information.

**J Gonzalez, MD Aesthetic Surgery (F. Jorge Gonzalez MD)**, 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 calling the office and requesting a revised copy t be sent in the mail or asking for one at the time of my next appointment.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

______________________________________________ ______________________
Print Name Date

______________________________________________ ______________________
Patient Signature Witness

# **<u>Patient Photograph Release Form</u>**

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of **J Gonzalez MD Aesthetic Surgery** Staff. Any photographs taken will become part of my medical records. My photographs are to be used for the purposes of the office and medical chart. I hereby and authorize **J Gonzalez MD Aesthetic Surgery** and staff to take my photos and use them only for my surgery record with **<u>Dr. Gonzalez</u>**. I understand these photos will not be used on the office website or in any publications.

You have the right to revoke this consent in writing.

I authorize/allow **J Gonzalez MD Aesthetic Surgery** to take photos the day of my Consultation.

Patient's Name: ________________________________________________________________________

Patient's Signature: ________________________________________________ Date: ________________

GONZALEZ MD
AESTHETIC SURGERY

# Authorization to Release Information

Many of our patients allow family members such as their spouse, parents or others to be present during their consultation. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have family members (spouse, parents or others) during your consultation with **Dr. Gonzalez**, you must sign this form. Signing this form will only give consent to release information to the family members indicated below. This consent form will not allow **J Gonzalez MD Aesthetic Surgery** to release any other information to these family members.

You have the right to revoke this consent in writing.

I authorize/allow **J Gonzalez MD Aesthetic Surgery** to release my information to the following individual(s):

1. ____________________________________________ Relation to Patient: __________________________
2. ____________________________________________ Relation to Patient: __________________________
3. ____________________________________________ Relation to Patient: __________________________

Patient Name: ____________________________________________________________________________________

Patient Signature: ______________________________________________ Date: _________________________