



### Consultation & Medical Questionnaire

NAME \_\_\_\_\_ DATE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SSN # \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_ IS IT OK TO MAIL? YES \_\_\_\_\_ NO \_\_\_\_\_

PHONE # (WORK) \_\_\_\_\_ (HOME) \_\_\_\_\_ (CELL) \_\_\_\_\_

Which phone number would you prefer we use when contacting you? Work \_\_\_ Home \_\_\_ Cell \_\_\_

IF YOU CHECKED HOME PHONE #, CAN WE LEAVE A DETAILED MESSAGE? Yes \_\_\_\_\_ No \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

Name/Phone of emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_

By which name do you prefer to be called - Circle one:

Nickname \_\_\_\_\_ 1<sup>st</sup> Name Mrs. Miss Ms. Mr. Dr. No preference

Describe the areas of concern that you would like to discuss with Dr. Clymer:

#### HOW DID YOU HEAR ABOUT US

Who can we thank for referring you? \_\_\_\_\_

Bellsouth Yellow Pages Nashville \_\_\_\_\_ Brentwood/Franklin \_\_\_\_\_ Murfreesboro \_\_\_\_\_

Newspaper \_\_\_\_\_ Other Publications \_\_\_\_\_ Internet/Website \_\_\_\_\_

Attended Program/Seminar \_\_\_\_\_ Word Of Mouth \_\_\_\_\_ Drive By \_\_\_\_\_ Your Doctor \_\_\_\_\_

Other (please specify) \_\_\_\_\_

How long have you considered pursuing cosmetic medical or surgical services? \_\_\_\_\_

Have you considered surgical improvement for your concerns? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you discussed the surgery with your family? Yes \_\_\_\_\_ No \_\_\_\_\_

Has anyone else in your family or a close friend had cosmetic or reconstructive surgery?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what was done? \_\_\_\_\_

#### MEDICAL HISTORY

Family Doctor/Primary Physician \_\_\_\_\_ Phone # \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_

Would you object if we contact your Dr. concerning your care at our office? Yes \_\_\_\_\_ No \_\_\_\_\_

When was your last eye examination? \_\_\_\_\_

Who is your eye doctor? \_\_\_\_\_ Phone # \_\_\_\_\_

List all surgeries since childhood:

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

List all prescription medications:

Medication: _____	Dose: _____	How many times a day? _____
Medication: _____	Dose: _____	How many times a day? _____
Medication: _____	Dose: _____	How many times a day? _____
Medication: _____	Dose: _____	How many times a day? _____
Medication: _____	Dose: _____	How many times a day? _____
Medication: _____	Dose: _____	How many times a day? _____

Allergies - Please list name of medication and what happened when you took it. (Include local anesthetics and Codeine) \_\_\_\_\_

Do you take Aspirin or any medication containing aspirin? Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you taken any steroid preparations in the past year? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you drink more than 6 cups of coffee per day? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you usually drink two or more alcoholic drinks a day? Yes \_\_\_\_\_ No \_\_\_\_\_

Please complete all of the following questions.

Have you or any family member ever had trouble with:

<b>EYES</b>	<b>Myself</b>	<b>Relative</b>	<b>Relationship to you</b>
Visual loss (one or both eyes)	Yes No	Yes No	_____
Dry eyes	Yes No	Yes No	_____
Itching or irritation of the eyes	Yes No	Yes No	_____
Blurred or double vision	Yes No	Yes No	_____
Crossed or lazy eyes	Yes No	Yes No	_____
Cornea problems	Yes No	Yes No	_____
Thyroid eye disease	Yes No	Yes No	_____
Wear glasses or contacts	Yes No	Yes No	_____
Previous eye or eyelids surgery	Yes No	Yes No	_____

If so, please describe what type: \_\_\_\_\_

<b>EYES</b>	<b>Myself</b>	<b>Relative</b>	<b>Relationship to you</b>
Difficulty breathing through nose	Yes No	Yes No	_____
Previous injury to nose	Yes No	Yes No	_____
Nasal allergies	Yes No	Yes No	_____
Frequent nose bleeds	Yes No	Yes No	_____
Sinus problems	Yes No	Yes No	_____
Nasal polyps	Yes No	Yes No	_____
Previous nasal or sinus surgery	Yes No	Yes No	_____
If so, please describe what type: _____			

<b>FACE / HEAD</b>	<b>Myself</b>	<b>Relative</b>	<b>Relationship to you</b>
Irritation to the face or neck	Yes No	Yes No	_____
History of radiation for acne treatment	Yes No	Yes No	_____
Acne	Yes No	Yes No	_____
Vitiligo	Yes No	Yes No	_____
Keloid Formation	Yes No	Yes No	_____
Previous face or neck surgery	Yes No	Yes No	_____
If so, please describe what type: _____			

<b>CARDIOVASCULAR</b>	<b>Myself</b>	<b>Relative</b>	<b>Relationship to you</b>
Angina, or history of chest pain	Yes No	Yes No	_____
Heart murmur	Yes No	Yes No	_____
Mitral Valve Prolapse	Yes No	Yes No	_____
History of heart attack	Yes No	Yes No	_____
Congenital heart disease	Yes No	Yes No	_____
Palpitations or irregular heartbeat	Yes No	Yes No	_____
Stroke	Yes No	Yes No	_____
High Blood Pressure	Yes No	Yes No	_____

<b>CHEST</b>	<b>Myself</b>	<b>Relative</b>	<b>Relationship to you</b>
Shortness of breath	Yes No	Yes No	_____
Shortness of breath when exerting yourself	Yes No	Yes No	_____
Asthma	Yes No	Yes No	_____
Chronic lung disease	Yes No	Yes No	_____
Coughing up blood	Yes No	Yes No	_____

<b>PSYCHIATRIC</b>	<b>Myself</b>	<b>Relative</b>	<b>Relationship to you</b>
Have you received psychiatric treatment?	Yes No	Yes No	_____
If so, were you hospitalized? Yes No			
Has there been any recent crisis in your life?	Yes No	Yes No	_____
Have you ever been treated for drug/alcohol dependency?	Yes No	Yes No	_____
Do you have claustrophobia?	Yes No	Yes No	_____

OTHER	Myself	Relative	Relationship to you
Ulcers or stomach problems	Yes No	Yes No	_____
Gallbladder trouble	Yes No	Yes No	_____
Seizures or convulsions	Yes No	Yes No	_____
Kidney problems or urinary tract infections	Yes No	Yes No	_____
History of tuberculosis	Yes No	Yes No	_____
Liver disorder; hepatitis or cirrhosis	Yes No	Yes No	_____
Spinal or back disorders	Yes No	Yes No	_____
Previous blood clots or thrombophlebitis	Yes No	Yes No	_____
Free bleeding or bleeding disorders	Yes No	Yes No	_____
History of blood transfusions	Yes No	Yes No	_____
Diabetes	Yes No	Yes No	_____
Autoimmune disease (Lupus, rheumatoid arthritis, etc).	Yes No	Yes No	_____
Are you pregnant?	Yes No		
Have you ever taken Acutane?	Yes No	Yes No	_____
Do you have a history of cold sores or fever blisters?	Yes No		
Have you ever had a positive blood test for HIV?	Yes No		

Please list any additional medical concerns: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any questions you would like addressed by Dr. Clymer or the staff: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

## Insurance Information

As a courtesy to our patients, we will file your charges for insurance eligible services with your insurance company; however, the following information must be filled out completely for your procedures to be filed with your insurance carrier. By signing below I am authorizing Clymer Facial Plastic Surgery P.C., Dr. Mark A. Clymer to furnish all the necessary information to my insurance company, which they may request to process claims, or to comply with any audits that may be requested by my insurance company. I also authorize transmission of my medical records by fax if the necessity should arise. Insurance deductibles, which have not been met, may require payment prior to your surgery. If this form is incomplete, you will be billed directly.

### Primary Insurance, Information

Primary Insurance \_\_\_\_\_

Address to mail claims \_\_\_\_\_

Telephone \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Policy Holder's SSN# \_\_\_\_\_ Policy Holder's Employment \_\_\_\_\_

Relationship to member \_\_\_\_\_ Self/Spouse/Child/Other

### Secondary Insurance Information

Secondary Insurance \_\_\_\_\_

Address to mail claims \_\_\_\_\_

Telephone \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Policy Holder's SSN# \_\_\_\_\_

Relationship to member \_\_\_\_\_ Self/Spouse/Child/Other

### Primary Care/Referring Physician Information

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

Referring Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Patients Marital Status \_\_\_\_\_ married \_\_\_\_\_ separated \_\_\_\_\_ divorced \_\_\_\_\_ single  
(This information is required by your insurance company. Used for insurance billing only).

Responsible Party's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian If Patient is under 18 \_\_\_\_\_ Date \_\_\_\_\_

By signing this form, I understand that if my insurance company does not pay the bill submitted by our office in full, I am responsible for any unpaid balance.

**Clymer Facial Plastic Surgery**  
**NOTICE OF PRIVACY PRACTICES**

**This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

**You have the right to obtain a paper copy of this Notice upon request.**

**Patient Health Information**

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

**How We Use Your Patient Health Information (PHI)**

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

**Examples of Treatment, Payment, and Health Care Operations**

**Treatment:** We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

**Payment:** We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

**Health Care Operations:** We will use and disclose your health information to conduct our standard internal information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

**Special Uses**

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Other Uses and Disclosures**

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

- . **Required by Law:** We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- . **Public Health Activities:** As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- . **Health oversight:** We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- . **Judicial and administrative proceedings:** We may disclose information in response to an appropriate subpoena or court order.
- . **Law enforcement purposes:** Subject to certain restrictions, we may disclose information required by law enforcement officials.
- . **Serious threat to health or safety:** We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person..

•**Workers Compensation:** We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

#### **Individual Rights**

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

**Request Restrictions:** You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

**Confidential Communications:** You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

**Inspect and Obtain Copies:** In most cases you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

**Amend Information:** If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

**Accounting of Disclosures:** You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

#### **Our Legal Duty**

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

#### **Changes in Privacy Practices**

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

#### **Complaints**

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Healthy and Human Services.

#### **Contact Person**

If you have any questions, requests, or complaints, please contact:  
Gayle Fox Practice Administrator, 1800 Mallory Ln. Ste A3, Brentwood, TN 37027  
(615)661-4005

**Effective Date: The effective date of this Notice is April 14, 2003**

American Academy of Facial Plastic &  
& Reconstructive Surgery  
American Academy of Cosmetic Surgery

Board Certified  
American Board of Facial Plastic  
& Reconstructive Surgery



### **Authorization To Use & Disclose Health Information**

I, \_\_\_\_\_, authorize Clymer Facial Plastic Surgery to use and disclose a copy of the specific health and medical information described below, under HIPAA regulations.

**Any medical records requested in conjunction and related to your medical care and/or diagnosis. Also included in this release could possibly be prescriptions called to a pharmacy, contact with your insurance company to pre-certify or pre-determine a proposed procedure on your behalf, procedures scheduled at a hospital or ambulatory surgery center on your behalf, any dictation or conversation with another physician regarding your medical care and/or diagnosis.**

I have reviewed and I understand this Authorization. I also understand that I have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. A photostatic copy of this authorization shall be as effective and valid as the original. I acknowledge that I have been given a Notice Of Privacy Practices for Clymer Facial Plastic Surgery.

By: \_\_\_\_\_

Patients Signature

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