Ernesto J. Ruas, M.D.
Cosmetic & Reconstructive Plastic Surgery

PATIENT INFORMATION: PLEASE PRINT ALL INFORMATION CLEARLY

Name _____ / / _____ _____ _____ _____
Last First MI **Date of Birth** **Age** **Sex** **Race**

_____ **Marital Status:** ❒ single ❒ separated ❒ widowed ❒ divorced ❒ other
SS # ❒ married Spouse: _____

( ) _____ ( ) _____ ❒ Parent: Mom / Dad ❒ Patient ❒ Guardian ( ) _____ ❒ Parent: Mom / Dad ❒ Patient ❒ Guardian
Home Phone **Cell Phone** **Work Phone**

Address _____
Street & Apt # City State Zip

E-mail _____ Preferred contact: ❒ home ❒ cell ❒ work
Do NOT contact me by: ❒ e-mail Do NOT contact me by: ❒ home ❒ cell ❒ work

Patient's Employer _____ **Occupation** _____

How did you hear about our practice? _____

IF PATIENT IS A MINOR

Mother's Name _____ **SS#** - - **Date of Birth** / /

Father's Name _____ **SS#** - - **Date of Birth** / /

EMERGENCY CONTACT
(Not in your household)

Name _____ **Relationship to patient** _____

Phone ( ) _____ ❒ home ❒ cell ❒ work

REFERRING PHYSICIAN

Name _____

Address _____

_____

Phone ( ) _____

PRIMARY CARE PHYSICIAN (if applicable)

Name _____

Address _____

_____

Phone ( ) _____

_____
Patient / Guardian signature

INSURANCE INFORMATION

THIS INFORMATION IS NECESSARY, PLEASE COMPLETE

Insurance Company _____

Subscriber's Name _____ **Relationship to patient** _____

Subscriber's SS# - - **Subscriber's Date of Birth** / /

Subscriber's Employer _____

Group #/Name _____ **Policy #** _____ **ID #** _____

May we provide the above physicians with a copy of Dr. Ruas' office note(s)? / /

Yes_____ No_____ / /

MEDICAL HISTORY

Please answer <u>all</u> questions.

What is your reason for today's visit? _____

1. When did this problem start? _____
2. Where is this problem located? _____
3. What makes this problem worse? _____
4. Are there any other symptoms associated with this problem? Yes _____ No _____

Describe _____

ALLERGIES

	Yes	No	
Latex	( )	( )	Effect _____
Penicillin	( )	( )	Effect _____
Betadine	( )	( )	Effect _____
Other Medication	_____		Effect _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

DRUG	**DOSE**	**FREQUENCY**

Do you need antibiotics prior to routine dental work? Yes _____ No _____

Aspirin Usage: Daily _____ Occasional _____ Rarely_____ Never _____

NSAIDS (Aleve, Ibuprofen, Advil, Motrin, etc.) Usage: Daily _____ Occasional _____ Rarely_____ Never _____

LIST ALL VITAMINS/MINERALS/SUPPLEMENTS YOU ARE CURRENTLY TAKING

_____

_____

_____

_____

_____

Please check all that apply

	Yes	No
General History		
Recent weight gain	( )	( )
Recent weight loss	( )	( )
Chronic fatigue	( )	( )
Skin rashes	( )	( )
HEENT History		
Wears glasses	( )	( )
Wears contacts	( )	( )
Vision loss	( )	( )
Dry eyes	( )	( )
Glaucoma	( )	( )
Hearing loss	( )	( )
Sinus trouble	( )	( )
Snoring/apnea	( )	( )
Pulmonary History		
Asthma	( )	( )
Pneumonia	( )	( )
COPD	( )	( )
Bronchitis	( )	( )
Emphysema	( )	( )
Cardiac History		
High blood pressure	( )	( )
High cholesterol	( )	( )
Arrhythmias/ irregular heart beat	( )	( )
Heart murmur	( )	( )
Scarlet fever	( )	( )
History of heart attack	( )	( )
Ankle swelling/LE edema	( )	( )
Chest pain/tightness	( )	( )
Heart Disease	( )	( )
Female/Breast History		
Breast mass	( )	( )
Nipple discharge	( )	( )
Lumps or recent changes	( )	( )
Breast feeding	( )	( )
Ulcer	( )	( )
Constipation	( )	( )
Diverticulitis	( )	( )
GERD/ acid reflux	( )	( )
Hemorrhoids	( )	( )
Irritable bowel	( )	( )

	Yes	No
Hepatic / Liver History		
Cirrhosis	( )	( )
Gall Stones	( )	( )
Jaundice	( )	( )
Hepatitis	( )	( )
Renal / Kidney History		
Kidney stones	( )	( )
Kidney failure	( )	( )
Kidney infections	( )	( )
UTI / bladder infections	( )	( )
Extremity History		
Spider veins	( )	( )
Varicose veins	( )	( )
Chronic swelling	( )	( )
Difficulty walking	( )	( )
Neuro/Psych History		
Seizures	( )	( )
Depression	( )	( )
Anxiety	( )	( )
Fibromyalgia	( )	( )
Paralysis	( )	( )
Migraines	( )	( )
Stroke	( )	( )
Hematologic/Blood History		
Bleeds/Bruises easily	( )	( )
Abdominal bleeding	( )	( )
Hemophilia	( )	( )
Clotting problems	( )	( )
History of DVT/blood clots	( )	( )
Anemia	( )	( )
Blood thinners	( )	( )
Infectious Disease History		
HIV	( )	( )
Cold Sores	( )	( )
Oral herpes	( )	( )
Genital herpes/warts	( )	( )
Gonorrhea	( )	( )
Syphilis	( )	( )
Chlamydia	( )	( )
HPV	( )	( )
Cancer	( )	( )

Year & Type _____

Past Surgical History

Please mark/circle all that apply. No mark means not applicable.

Facial Cosmetic Surgery — MONTH / YEAR OF SURGERY

_____ brow lift _____
_____ upper blepharoplasty (EYELID LIFT) _____
_____ lower blepharoplasty (EYELID LIFT) _____
_____ facelift _____
_____ mid-facelift _____
_____ neck lift _____
_____ laser resurfacing _____
_____ dermabrasion _____
_____ hair transplant _____
_____ chemical peel _____

Head & Neck Surgery

_____ facial fracture surgery _____
_____ rhinoplasty (NOSE SURGERY) _____
_____ otoplasty (EAR RE-SHAPING) _____
_____ ptosis correction (DROOPY EYELIDS) _____
_____ Lasik / RK surgery _____
_____ tonsillectomy / adenoidectomy _____
_____ neurosurgery _____

Breast Surgery

_____ breast augmentation: Saline / Silicone _____
_____ breast reduction / gynecomastia _____
_____ mastopexy (BREAST LIFT) _____
_____ mastectomy: L-breast / R-breast _____
_____ reconstruction: _____
implant / TRAM / lat dorsi
_____ breast biopsy: L-breast / R-breast _____

Trunk Surgery

_____ abdominoplasty (TUMMY TUCK) _____
_____ liposuction: abdomen / chest / flanks / hips _____
_____ heart surgery / lung surgery _____

Pelvic Surgery — MONTH / YEAR OF SURGERY

_____ C-section _____
_____ tubal ligation (TUBES TIED) _____
_____ hysterectomy _____
_____ BSO (OVARIES REMOVED) _____

Abdominal Surgery

_____ appendectomy (APPENDIX REMOVAL) _____
_____ cholecystectomy (GALL BLADDER REMOVAL) _____
open / endoscopic
_____ gastric bypass / banding _____
_____ splenectomy (SPLEEN REMOVAL) _____
_____ bowel resection _____
_____ hernia repair _____

Extremity Surgery

_____ brachioplasty (ARM LIFT) _____
_____ liposuction: _____
arm / knees / inner thigh / saddle bags
_____ buttocks lift / buttocks implant _____
_____ body lift _____
_____ thigh lift _____
_____ varicose vein surgery _____
_____ hand surgery _____
_____ carpal tunnel release _____

Other Past Surgical History

_____ Surgeries other than what I was asked:

_____ _____
_____ _____
_____ _____

Please list any complications from Anesthesia: _____

Women Only:

	Yes	No
Menopausal?	( )	( )
Regular Periods?	( )	( )

Number of Births: _____

Please list any pertinent **Family Medical** history:_____

_____

Social History:

_____I drink alcohol, ____ daily ____ socially ____ heavily on weekends

_____ I use(d) recreational drugs. If yes, please list _____

_____ I smoke _____ packs per day for _____ years

_____ I exercise, approximately _____ times per week

_____ I drink caffeinated drinks (coffee, tea, diet and regular soft drinks, etc.), approximately _____ per day

Occupation: _____

Height: _____ Current Weight: _____

Other Information:

_____

_____

_____

_____

_____

_____

_____ _____ _____ _____

PATIENT and/or GUARDIAN SIGNATURE | DATE | PHYSICIAN'S SIGNATURE | DATE

AGREEMENT TO GUARANTEE PAYMENT/ASSIGN BENEFITS/RELEASE INFORMATION

The undersigned agrees, whether as agent or patient, to accept full responsibility for all charges for services ordered on behalf of the patient and by the physician attending the patient, and agrees to pay all charges at time of service or upon receipt of statement. I understand that I am responsible for any costs incurred in the reasonable attorney fees and/or court costs. This agreement is valid for the services provided on this date and for all future visits and services until revoked by me.

I authorize third parties to pay directly to the physician insurance benefits due for services rendered on behalf of the patient.

I authorize the physician to furnish my insurance company and/or other responsible third party payor or their representatives any medical information necessary to process this claim.

_____

PATIENT and/or GUARDIAN DATE

AGREEMENT TO GUARANTEE PAYMENT FOR OUT OF NETWORK/UNAUTHORIZED COVERAGE

I understand that the services I am requesting to be rendered by Ernesto Ruas, M.D. on _____ are out of network or unauthorized by insurance (HMO/PPO/Indemnity/Auto Insurance/Worker's Compensation/Medipass, etc., coverage). I understand that I will be held responsible for these charges.

_____

PATIENT and/or GUARDIAN DATE

ERNESTO RUAS, MD, PA

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on an answering machine, mobile voice mail, email or with a household family member.

  [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.

  [ ] Please check here if you do not want us to leave a message on your mobile voice mail.

[ ] **Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.**

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information_____
  _____

- You may request a copy of and you have the right to read our "*Notice of Patient Privacy Practices"* prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print):_____

_____ _____ _____

Signature Print name of person signing if other than patient Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ] RELATIONSHIP_____

FOR OFFICE USE ONLY

Patient refused to sign the form. Reason: _____ Date: _____

ERNESTO RUAS, MD, PA

AUTHORIZATION FOR THE TAKING AND PUBLICATION OF PHOTOGRAPHS/CINEMATOGRAPHY/DVD/TESTIMONIALS

In connection with medical services that I, _____,
am receiving or shall be receiving, do hereby authorize that photography/cinematography/DVD/ may be taken of me or parts of my body, under the following conditions:

1. The photographs/cinematography/DVD may be taken only with the consent of my healthcare provider, and under such circumstances and at such times as may be approved by him/her.

2. The photographs/cinematography/DVD shall be taken by my healthcare provider or by a photographer approved by my healthcare provider and who has signed a business associate agreement with my healthcare provider.

3. The photographs/cinematography/DVD/video cassettes shall be used for medical records and if, in the judgement of my healthcare provider, medical research, education or science will be benefited by their use, such photographs/cinematography/DVD/video cassettes and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which he/she may deem proper in the interest of medical education, knowledge, research. It is specifically understood that in any such publication or use, all reasonable effort will be made so that I shall not be identified by name.

4. I authorize my healthcare provider to use testimonials given by me or to use photographs, cinematography or DVD in a professional manor for marketing purposes. I understand this information may also be posted on social media outlets or used as directed by my healthcare provider. The use of my information for marketing purposes has been fully explained to me. [ ] Please check the box if you understand and authorize section number 4.

5. I understand that I may be recognized and identifiable in the photographs/cinematography/ DVD, though all reasonable efforts will be made to avoid personal identification. I understand I have the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, we must receive the revocation in writing. The revocation must include:
   - The patient's full name and address
   - The patient's desire to revoke this authorization
   - The effective date of this revocation
   - The patient's and/or patient's agent/representative's signature
   - The relationship to the patient, if applicable

   **We will accept written revocations of this authorization by Certified U.S. mail only.

This Authorization shall be non-expiring except as listed below.

If this authorization is to be used solely for marketing purposes, then this authorization shall expire on: DATE_____. After this date, we can no longer use or disclose your protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____
Patient's Signature Patient's Agent/Representative's Signature & Relationship

_____ _____
Signature of Witness Date