CAPELLA PLASTIC SURGERY
PATIENT INFORMATION FORM

First Name_____ **Middle Initial**____ **Last Name**_____
**********As it appears on your driver's license **********

Address_____**Apt** _____ **Home #** _____

City_____**State**_____**Zip**_____ **Cell #** _____

Social Security Number_____ **Work #** _____

E-Mail_____ **Birth Date** _____/_____/_____ **Age**_____

Sex_____ **Marital Status**_____ **Name of Spouse**_____

Your Occupation: _____

Does Dr. Capella and/or his staff have permission to contact you via e-mail: **YES / NO**

Does Dr. Capella and/or his staff have your permission to contact you and leave a voicemail message: **YES / NO**

In Case of Emergency, Contact: _____

Phone #:_____ **Relationship to Patient:** _____

Primary Care Physician: _____ **Office Phone:** _____

How did you hear about us:

Referred by a patient ☐ **Patient's Name**_____

Referred by physician ☐ **Physician's Name**_____

Google ☐ **Obesity Help** ☐ **Vitals** ☐ **Other Social media Website(s)**_____

Primary reason for visit: _____

Other procedures that I am interested in (Please circle or highlight all that apply)

Liposuction	Face Lift	Breast Augmentation	Scar Revisions
Tummy Tuck	Neck Lift	Breast Reduction	Botox Injections
Body Lift	Eyelid Surgery	Breast Lift	Restylane Injections
Arm Lift	Brow Lift	Male Breast Surgery	Fat Grafting
Buttock Lift	Forehead Lift	Chemical Peels	Thigh Lift

545 Island Road, Suite 2A
Ramsey, NJ 07446
Telephone 201.818.9199
Fax 201.818.0311

461 Park Avenue South, 7th Floor
New York, NY 10016
Telephone 212.772.1000

www.CapellaPlasticSurgery.net

Health History

ANSWER ALL QUESTIONS BY CIRCLING Yes (Y) or No (N). Provide additional information as needed.

Have you had any previous surgery (including cosmetic procedures)?.....Y N

If yes, please list (include dates):

___/___/___ _____

___/___/___ _____

___/___/___ _____

___/___/___ _____

___/___/___ _____

___/___/___ _____

Do you have *or have you ever had* any of the following:

Have you ever seen a Cardiologist?.....Y N
Rheumatic Fever or Rheumatic Heart Disease?.....Y N
Heart Disease?.....Y N
Heart Attack?.....Y N
Heart Murmur?.....Y N
Hypertention?.....Y N
Angina?.....Y N
Stroke?.....Y N

Asthma/Respiratory Problems?.....Y N
Sleep Apnea?.....Y N
Tuberculosis / Emphysema?.....Y N

Diabetes?.....Y N
Kidney Disease?.....Y N
Bleeding Tendency?.....Y N
DVT (blood clot in legs)?.....Y N
Pulmonary Embolism?.....Y N
Seizures?.....Y N

Cancer (including skin cancer)?..... Y N
If yes, what type?_____

Herpes Zoster (Shingles)?.....Y N
Herpes?.....Y N
HIV or AIDS?.....Y N
Hepatitis (A, B, C, D, E)?.....Y N

Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder?.....Y N
Have you ever been hospitalized for above?.....Y N

If yes, please describe:_____

_____

Do you drink alcohol?.....Y N How often? _____
Do you use any recreational drugs?.....Y N

If yes, what type: _____

Have any of your close relatives had any of these diseases? List family member:

Anemia _____

Bleeding Tendency _____

Diabetes _____

Heart Attack _____

Heart Disease _____

Hypertension _____

Stroke _____

Cancer _____

Mental Disorder _____

What was your maximum weight?_____
(For women please include maximum pregnancy weight)

Current Weight _____

Height: Feet ____ Inches _____

For Women Only

Number of Pregnancies_____ Number of Children _____

Birth Control Pills?.....Y N Other Contraceptives_____

Date of last Mammography_____

Family History of Breast Cancer?.....Y N

I understand the importance of a truthful and complete Health History to assist my doctor in providing the best care possible. By my signature below, I attest that the medical information I have given is true and accurate.

_____
Signature of Patient

_____
Name Printed Above

_____
Date Signed

Drug Reactions/Allergies/Latex Sensitivity

Some patients cannot take certain medications such as penicillin because of allergic reactions. Other patients experience reactions such as nausea/vomiting from narcotic pain medications (codeine, morphine, Demerol®, Vicodin®, Percocet®, etc.). Please list below any known drug allergies, reactions, or sensitivities.

Medication Name Type of Drug Reaction/Allergy

1.
2.
3.
4.

_____I do not have known drug allergies, drug reactions, or latex sensitivity.

Prescription Medications

Please list all prescription medications you currently take:

1.
2.
3.
4.

_____I am not currently taking any prescription medications.

Nonprescription Medications/Dietary Supplements/Vitamins/"Herbs"/Minerals

Many patients take nonprescription medications such as aspirin, anti-inflammatories (Advil®, Motrin®, Aleve®), and other preparations that can be purchased without a prescription (dietary supplements, vitamins, "herbs," and minerals). Many of these can increase risk of bleeding during and after surgery or react with prescription medications. If you currently take items in this category, please list them below. Please discontinue taking all nonprescription medications, dietary supplements, vitamins, herbs, and minerals for a minimum of 10 days before and after surgery.

1.
2.
3.

_____I am not currently taking nonprescription medications, dietary supplements, vitamins, herbs, or minerals.

Smoking, Secondhand Smoke Exposure, Nicotine Products (Patch, Gum, Nasal Spray)

Patients who are currently smoking, use tobacco products, or use nicotine products (patch, gum, or nasal spray) are at a greater risk for significant surgical complications of skin dying and delayed healing. Individuals exposed to secondhand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk for these complications. Please indicate your current status regarding these items below:

_____I am a nonsmoker and do not use nicotine products. I understand the risk of secondhand smoke exposure causing surgical complications.

_____I am a smoker or use tobacco/nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

_____I have smoked and stopped approximately _____ ago. I understand I may still have the effects and therefore, risks from smoking in my system if not enough time has lapsed.

Date: _____ Signature: _____

Joseph F. Capella, M.D., F.A.C.S.
Plastic & Reconstructive Surgery
Diplomate American Board of Plastic Surgery
Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

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212-772-1000

Patient Information

Patient Name _____ Date of Birth _____/____/_____

Photograph Consent

I hereby acknowledge that photographs will be taken of me / parts of my body by a member of the Capella Plastic Surgery staff, both before and after surgery.

I hereby give consent for these photographs to be used under the following circumstance:

Photographs taken of me or parts of my body will be used solely for the purpose of my medical care with Capella Plastic Surgery. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical record at Capella Plastic Surgery.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form supersedes any other photo consent forms dated prior to the date written below. This consent may be revoked at any time by written request.

_____ _____

Signature (Patient or Parent/Guardian if Patient is under 18) Date

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MEDICAL RECORDS RELEASE

I hereby authorize and request the release of my medical records in your possession, including all lab work to the office of Capella Plastic Surgery, Joseph F. Capella, M.D. All records requested can be faxed to (201) 818-0311 attention Macey Rainey or Kerry Thurston.

Patients Name: _____

Address: _____

DOB: _____

_____ _____

Signature of Patient **Name Signed**

_____

Date

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.
There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. Please visit www.hhs.gov for additional information. We have adopted the following policies:

✓ Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

✓ It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

✓ The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

✓ You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

✓ You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

✓ Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

✓ We agree to provide patients with access to their records in accordance with state and federal laws.

✓ We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

✓ You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ **Date:** _____

MOST COMMUNICATION WITH OUR OFFICE IS VIA E-MAIL
CONSENT FOR USE OF ELECTRONIC COMMUNICATION

It may be useful during the course of treatment, to communicate by email, text message (e.g. "SMS"), video conferencing, social media, or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with *Capella Plastic Surgery*, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with *Capella Plastic Surgery*
- Third parties on the Internet such as server administrators and others who monitor and/or intercept Internet traffic

Consent to the use of electronic messages includes your agreement with the following conditions:

- All electronic messages to or from you concerning diagnosis or treatment may be printed out or stored electronically by Capella Plastic Surgery and made part of your medical record.
- Capella Plastic Surgery may forward messages internally to staff, and agents as necessary for diagnosis, treatment, payment, health care operations, and other purposes. *Capella Plastic Surgery* will not, however, forward messages to independent third-parties without your prior written authorization, except as permitted or required by law.
- Although *Capella Plastic Surgery* will endeavor to read and respond promptly to a message from you, *Capella Plastic Surgery* cannot guarantee that any particular message will be read and responded to within any particular period of time. Thus, you agree that you will not use email or other electronic messages for medical emergencies or other time-sensitive matters.
- If your message requires or invites a response from *DR. Joseph Capella or Staff* and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether the intended recipient received the message and when the recipient will respond.
- You should not use electronic messages for communications regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- You are responsible for informing *Capella Plastic Surgery* of any types of information you do not want to be sent by electronic message (in addition to those set out above).
- You are responsible for protecting your password or other means of access to electronic messages. *Capella Plastic Surgery* is not liable for breaches of confidentiality caused by you or any third-party.
- *Capella Plastic* will not knowingly engage in electronic messages that are unlawful, such as any that would result in unlawful practice of medicine across state lines.
- It is your responsibility to follow up and/or schedule an appointment, if warranted.
- Capella Plastic Surgery office is a HIPPA Compliant Practice.

By signing this form I acknowledge that I have read and fully understand the risks, including but not limited to confidentiality of treatment, of transmitting my protected health information by unsecured means; the limitations; the conditions of use, and instructions for use of the selected electronic communication. I understand and accept the risks associated with the use of electronic communications with the Physician and the Physician's staff. I also understand that I am not required to sign this agreement in order to receive treatment.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using electronic communication may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these methods with a full understanding of the risk.

I also understand that I or the Physician may, at any time, withdraw this option of electronic communications by providing the other party with written notice of such withdrawal.

_____ _____

Signature of Patient Date