Dr. Abdel K. Fustok

Medical History ***DATE:***

~~~~~~

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent. ***PLEASE PRINT CLEARLY***

~~~~~~

Patient's Name:_____ D.O.B:_____

Age:_____ Height:_____ Weight:_____ Email:_____

Referred by: (circle one) ***TV Commercial*** ***Radio Ad*** ***Phone Book*** ***Other:***_____

Procedure(s) of interest: (see complete list attached) _____

List any discomfort associated with procedure(s) of interest: (see list attached) _____

_____

Have you seen a physician with regards to these symptoms? (circle one) YES NO

If YES, what treatment(s) or medication(s) were prescribed: _____

_____

Do you smoke? (circle one) YES NO > Started/Stopped _____ A pack lasts_____

Do you drink alcohol? (circle one) YES NO > ***Daily*** ***Occasionally*** ***Weekly*** ***Rarely***

Have you ever had a blood transfusion? (circle one) YES NO

Have you been tested for HIV? (circle one) YES NO

Are you currently taking ANY medication(s), Diet Pills, Vitamins, Herbs? (circle one) YES NO

If YES, please list:_____

Frequency: (example – Daily or Twice Daily for 4 months)_____

*****Are you allergic to ANY medication(s)? (circle one) YES NO**

If YES, please list: _____

Please list ANY previous surgery: _____

_____

Have you or any blood relative had:

HISTORY OF:	YES	NO	WHO
High Blood Pressure			
Diabetes			
Heart Problems			
Anemia/Bleeding			
Breast Cancer/Cancer (any type)			
Stroke			
AIDS			
Psychiatric Illness			
Liver Disease/Hepatitis			
Asthma/Bronchitis/TB			
Thyroid			

Medical Patient Questionnaire

QUESTION	*YES*	*NO*
Who is your family physician?		
Have you ever been to a dermatologist or cosmetic plastic surgeon? If, YES, who?		
Have you ever had anesthesia for a medical or dental procedure? Any problems?		
Has any member of your family had a serious reaction to anesthesia used for surgery?		
Do you have sinus problems or environmental allergies?		
Do you use any type of inhaler?		
Are you allergic to neosporin or polysporin?		
Are you allergic to adhesive tape?		
Do you consume caffeine: ***Circle all that apply****: coffee, cola, tea, etc?*		
Do you use aspirin or ibuprofen products routinely?		
Do you have any type of medical implant(s)?		
Have you ever been treated with one of the following in the past year: Interferon, Radiation, Transfusions, ACTH, Chemotherapy or Cortisone/Prednisone?		
Have you ever had scarlet or rheumatic fever?		
Have you ever had any treatment that included the use of hormones or steroids?		
Do you bleed or bruise easily?		
Are you a slow or poor healer?		

Do you ever get cold sores or fever blisters?		
Have you ever had severe sunburn?		
Do you use a tanning salon, tanning gels or lotions?(for laser patients only)		
Do you shave or wax any area on your face?(for laser patients only)		
Have you ever had a problem with acne?		
Does your skin scar easily?		
Have you ever used Retin A, Accutane, Renova or Glycolic Acids?		
Have you ever had injections of collagen?		
Have you experienced a significant weight loss or gain in the past year? ***Circle one and list amount of weight.***		
Are you on a special diet?		
Do you exercise regularly? *_____: Days a week* *_____: Times spent a day* *_____: Type of exercise*		
Does exercise cause a shortness of breath?		
Have you had a recent physical examination, If so when? *_____:**Date***		
Do you have back problems?		
Do you have trouble sleeping?		
Do you wear glasses or contacts?		
Do you have problems with dry eyes?		
Do you feel you have a high level of stress?		
Have you ever had a serious reaction to perfumes, cosmetics or skin care products?		
Is there ANYTHING else you feel is important for us to know?		

PROCEDURE LIST: ***(please circle)***

Bilateral Reduction Mammoplasty (breast reduction)
Bilateral Augmentation Mammoplasty (breast enlargement)
Bracheoplasty (Arms)
Rhytidectomy (facelift)
Upper Lid Blepharoplasty (upper lids)
Lower Lid Blepharoplasty (lower lids)
Hand Surgery
Scar Revision
Tattoo Removal
Otoplasty (ear surgery)
Breast Reconstruction
Abdominal Wall Surgery
Liposuction
Mastopexy (breast lift)
Mole or Cyst Removal
Rhinoplasty (nose surgery)
Sclerotherapy (vein treatment)
Endermologie (cellulite treatment)
Restylane (to add fullness to facial features)
Botox (to rid facial lines)
Laser Hair Removal
Microdermbrasion (power peel)

POSSIBLE SYMPTOMS FOR INSURANCE RELATED PROBLEMS LISTED ABOVE (please circle:)

back pain
neck pain
shoulder indentations
breast heaviness
vision problems
shooting pains
keloided scar
skin discoloration
posture problems
snoring
weight loss/gain
allergies
dry mouth
shoulder pain
breast pain
rash/discoloration
numbness
heaviness in lids
acne
depression
open wound
abdominal pain
sagginess
stuffiness
sneezing
drainage
problem exercising
headaches
sleeping trouble
shortness of breath
breast hardness
burning sensations
fatigue
broken nose
constipation
limited mobility
sinus infections
nose bleeds
itching

If you are currently taking any herbs, vitamins or diet pills please inform us.

Examples: Metabolife, Xenedrine, Metabolite, Ephedrine (Ma Huang), Feverfew, Ginger, Ginkgo(Ginkgo Biloba), Ginseng, Goldenseal, Kava-Kava, Licorice, Valerian,Vitamin E.

LIST ALL HERBS AND VITAMINS:

_____

_____

_____

****Please stop taking all herbs, vitamins and diet pills at least two weeks prior to surgery.**

_____

Signature **Date**

I hereby acknowledge that I understand that my medical information may not be used or disclosed without my authorization. (If you have any questions regarding the HIPPA laws please ask the receptionist)

Date: _____

Patient Signature: _____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that my healthcare provider is a non-participating out-of-network provider and that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original..

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____

Patient Signature

_____

Date

Compliance & Disclosure under Texas Occupations Code - Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility (solely based on the quality and safety of care, reputation of patient satisfaction) and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor has disclosed to me, at the time of initial contact and at the time of referral with respect to my choice of facility (solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor and facility): (A) his affiliation, if any, with the facility for whom the patient is referred and (B) that he will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.

Facility with affiliation and remuneration: Humble Surgical Hospital, First Street Surgical, and First Street Hospital

I certify that I was informed of the effective alternative resources reasonable available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity.

I certify that my attending physician(s) has made referrals to the other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving, and for provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan for out-of-network coverage.

I have read and fully understand this Disclosure and Authorization Form. I hereby authorize this referral to non-participating and out-of-network provider(s) or entities as named above.

Patient Name (print)	Signature of Patient	Date

Abdel K. Fustok, M.D.
6750 West Loop South, Suite 830
Bellaire, Texas 77401
713-621-6655

Patient Consent for Disclosure of Information

I authorize the release of my protected health information / financial responsibilities to the following person(s):

1. Name: _____

   Address: _____

   Phone: _____

   Relation to patient: _____

2. Name: _____

   Address: _____

   Phone: _____

   Relation to patient: _____

Limitations on the information you may release subject to this Release Form are as follows:

_____

_____

_____

{ }I DO NOT AUTHORIZE THE RELEASE OF MY INFORMATION TO ANYONE.

_____

Patient Signature Date

By signing this form, I authorize you to release confidential health information and/or financial obligations about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) listed above.