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:_____

How did you hear about us?

_____

If seeing doctor for a breast reduction, please give BRA size_____Did you BreastFeed:_____

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

_____

_____

Do you smoke/Vape? (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 tested positive for HIV? (circle one) NO YES

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 All previous surgeries: _____**

_____

Total Pregnancies: _____

Total Live births: _____Abortions:_____ Miscarriages:_____

C-Sections:_____

Please list sex and age of each child:_____

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			

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

Bilateral Reduction Mammoplasty (breast reduction)
Bilateral Augmentation Mammoplasty (breast enlargement)
BIOTE' (Hormone Replacement therapy)
Brachioplasty (Arms)
Rhytidectomy (facelift)
Upper Lid Blepharoplasty (upper lids)
Lower Lid Blepharoplasty (lower lids)
Hand Surgery
Scar Revision
Otoplasty (ear surgery)
Breast Reconstruction
Abdominal Wall Surgery
Liposuction
Mastopexy (breast lift)
Mole or Cyst Removal
Rhinoplasty (nose surgery)
Sclerotherapy (vein treatment)
Restylane (to add fullness to facial features)
Botox/Dysport (to rid facial lines)
*Other*_____

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

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

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, energy drinks etc? Please specify		
Do you use aspirin or ibuprofen products routinely?		
Are you taking birth control pills?		
Could you be pregnant?		
Did you nurse, or are you nursing your children?		
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 experience Migraine Headaches?		
Have you been diagnosed with or experience Hyperhidrosis?(excessive sweating)		
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 Fillers, Botox, Dysport etc…?		
Have you experienced a significant weight loss or gain in the past year? **Circle one and list amount of weight.**		

QUESTIONS	YES	NO
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?		

_____

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**

Abdel K. Fustok, MD, PA
6750 West Loop South, Suite 830
Bellaire, Texas 77401
Ph. 713-621-6655 Fax: 713-621-2139

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 also authorize** my records to be released in the future with regards to my surgery
For example: FMLA, LEGAL OFFICES, Other Doctor's, etc….

{ } **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.

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: _____

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, Westside 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

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

ABDEL K. FUSTOK, MD
6750 West Loop South, Ste 830 ● Bellaire,TX 77401 ● 713-621-6655

NO SHOW/CANCELLATION POLICY

In order to provide the highest quality care to our patients, we have established a formal "No show/Cancellation policy". This is intended to increase physician and staff productivity, to improve timely access to all patients, and to reduce/eliminate empty slots in the schedule.

We understand there may be circumstances that require you to cancel an appointment, however we require that you notify out office at least 48 hours in advance to avoid charges.

APPOINTMENT CONFIRMATION PROCEDURE

One of our staff will call you the day before to confirm your appointment as a friendly reminder. We also send a reminder email 48 hours before as well. If we can't reach you, it is your responsibility to call us back within 48 hours of your appointment if you need to cancel/reschedule it.

TO RESCHEDULE APPOINTMENT

New or established patients with 2 or more no shows will be charged the office visit (or copay), before booking their next appointment. You will not be refunded the service charge if you miss the appointment, resulting in paying for the office fees again upon booking.

_____

Patient Signature (if patient is a minor, legal representative must sign consent) Date