Patient Information

Name:____

Address;____

City:______________________ State:______ Zip:__________

Home Phone:____

Work Phone:____

Cell Phone:____

E-mail:____

Preferred Method of Contact:___________________________

Date of Birth:______________Sex:___Marital Status:_______

Social Security Number:__________-__________-_________

Student: Y N Occupation:___________________________

Employer:____

Patient's Spouse/Guardian

Spouse/Guardian:_____________________________________

Address:____

City:______________________ State:______ Zip:__________

Home Phone:____

Work Phone:____

Reason for Consultation

____

____

____

____

____

____

Whom May We Thank for Referring You?

Name:____

Other: Newspaper____ Radio ____ TV ____ Seminar ______

Staff ___ Yellow Pages ____ Other ______________

Primary Care Physician

Name:____

Address:____

City:______________________ State:______ Zip:__________

Phone:____

Insured/Responsible Party

Insured's Name:_______________________________________

Relationship to Patient:________________________________

Address;____

City:______________________ State:______ Zip:__________

Home Phone:____

Work Phone :____

Date of Birth:______________Sex:___Marital Status:_______

Social Security Number : __________-________-_________

Employer:____

Insurance Carrier:_____________________________________

Insurance Phone Number:______________________________

Policy #:_________________________ Group #:___________

Is this Plan a: PPO________ POS________ HMO_________

Are Referrals Required? ______ Are we in network?________

I certify the above information is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not covered by insurance. I also have received a Notice of Privacy Practices and Disclosure of Investment from the CBBC Center for Hair Restoration.

Signature:___________________________ Date:__________

Update Signature:_____________________ Date:__________

Update Signature:_____________________ Date:__________

CENTER FOR HAIR RESTORATION

Patient Name: ___________________________

Male Patient Medical History

Allergies:

Are you allergic to local anesthesia? ❑Yes ❑No
Please list any medical allergies as well as reactions**:**

____
____

Major Illnesses/Medical History:

How many years have you experienced hair loss: ____

If you answer yes to any of the following, please include date of diagnosis or onset.

			Date
Heart disease	❑Yes	❑No	______________
High Blood Pressure	❑Yes	❑No	______________
Chest pain	❑Yes	❑No	______________
Diabetes	❑Yes	❑No	______________
Cancer	❑Yes	❑No	______________
Kidney Disease	❑Yes	❑No	______________
Asthma	❑Yes	❑No	______________
Thyroid Disorder	❑Yes	❑No	______________
Hypoactive	❑Yes	❑No	______________
Hyperactive	❑Yes	❑No	______________
Hepatitis	❑Yes	❑No	______________
Anemia	❑Yes	❑No	______________

			Date
Seizure Disorder	❑Yes	❑No	______________
Anxiety Disorder	❑Yes	❑No	______________
Depression	❑Yes	❑No	______________
Scarlet or Rheumatic Fever	❑Yes	❑No	______________
Glaucoma	❑Yes	❑No	______________
Cataract	❑Yes	❑No	______________
Arthritis	❑Yes	❑No	______________
Tuberculosis	❑Yes	❑No	______________
Blood Clots	❑Yes	❑No	______________
Bleeding Disorder	❑Yes	❑No	______________

Other:

____
____

Medication History:

Do you take medication to help prevent hair loss? ❑Yes ❑No ____
Do you use products that help prevent hair loss? ❑Yes ❑No ____

Please include **all prescription and non-prescription medications** you take as well as the dosage and instruction for use. Include separate sheet if necessary.

Medication/Strength	How often is it taken?	Why do you take this medication?

Do you routinely use aspirin or aspirin products (including Advil, Aleve or the generic equivalent)? ❑Yes ❑No

Surgical/Procedure History:

Have you had a previous hair restoration procedure(s)? ❑Yes ❑No If yes, provide details including dates: ______________

____

Have you ever had a surgical procedure (operation)? ❑Yes ❑No If yes, please provide details including dates:

Date	Type/name of procedure	Anesthesia or wound complications:

CBBC Center for Hair Restoration · 5575 Warren Parkway, Suite 304/307 · Frisco, Texas 75034
Appointments 214-578-5905 · Main 214-618-4000 · Fax 214-618-6203 · www.cbbchairrestoration.com

Male Patient Medical History continued

Health Maintenance History:

When was your most recent complete physical? ____
Have you had a Chest X-ray or EKG within the past year? ❑Yes ❑No If yes, when was this performed?___________________

Social History:

Do you currently smoke? ❑Yes ❑No Have you smoked in the past? ❑Yes ❑No If yes, provide details: _________________ _______________________________________

❑Cigarettes ____PPD x ____ years ❑Cigars _____Per day x _____years Other: ____

Do you drink alcohol? ❑Yes ❑No If yes, what type? ❑Wine ❑Mixed Drinks ❑Beer ❑Liquor How often? ❑Daily ❑1-2 x week ❑1-2 x month ❑1-2 x year
Do you live alone? ❑Yes ❑No If no, who lives with you? ❑Spouse ❑Children ❑Significant other ❑ Other relative ❑Other: ________________________

If you were to have a surgical procedure, who would assist you at home during your recovery? ____

Family History of Hair Loss:

Paternal: ____ Maternal: ____

Family History:

Have any blood relatives had:

Condition	If yes, who had this? Please indication maternal or paternal (mother or father) relative.		
Diabetes	❑Yes	❑No	____________________
Breast Cancer	❑Yes	❑No	____________________
Other Cancer	❑Yes	❑No	____________________
Bleeding Disorder	❑Yes	❑No	____________________
Heart Disease	❑Yes	❑No	____________________
Hypertension	❑Yes	❑No	____________________
Problems with Anesthesia	❑Yes	❑No	____________________

❑ **I am adopted and do not know my family history.**

Additional:

Ethnicity: ❑ Caucasian/White ❑ African American/Black ❑Asian ❑Hispanic/Latino ❑Native American ❑Middle Eastern ❑Other _________________

Are you ❑ right or ❑ left handed?

Height: _________________________

My Normal Weight: ___________________________

Please list any additional medical conditions, illnesses, or handicaps you may have: __________________________________
____
____
____

The information I have provided about my medical history is accurate and complete to the best of my knowledge.

Patient's signature: ____ Date: _____________________

Financial Policy

We are committed to providing you with the best possible health care, and we are pleased to discuss our professional fees with you at any time. In order to achieve these goals, we need your assistance and your understanding of our payment policies. Please ask if you have any questions about our fees, your responsibility, or the financial policy.

All patients must complete our Patient Information Form and inform our office of any changes in address or insurance. In order for us to treat and care for our patients, we must have complete and correct information.

We expect TOTAL PAYMENT two weeks prior to all aesthetic procedures unless you have been pre-approved with one of our financial plans. We accept cash, check, Mastercard, Visa, Discover, and American Express. There will be a $25.00 service charge for any returned checks.

The charges on your account with our office will reflect ***our*** doctor's fees only, *unless otherwise noted.* Any hospital, x-ray, laboratory, anesthesia, pathology, etc. will be billed by the provider performing the service.

If at any time after your initial procedure you feel that you need a secondary procedure or revision, additional charges will apply.

Signature:____ Date;_______________________________

CBBC
CENTER FOR
HAIR RESTORATION

Photography Release

Dated: ___________________________

I, _____________________________________(patient's name) hereby give ***CBBC Center For Hair Restoration*** the absolute and irrevocable right and permission, with respect to photographs they have taken of me and/or in which I may be included with others:

a. To copyright the same in their own name or any other name they may choose.
b. To use, re-use, publish and/or re-publish the same in whole or in part, individually, or in conjunction with other photographs, in any medium and for any purpose whatsoever, including (but not limited to) illustration, promotion and/or advertising and/or trade.
c. To use my name in connection therewith if they so choose.

I hereby release and discharge ***CBBC Center For Hair Restoration*** from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.

This authorization and release shall also ensure to the benefit of the legal representatives, licensees, and assignees of ***CBBC Center For Hair Restoration*** as well as the person(s) for whom they took the photographs.

______ Please **DO NOT use my photos** on the website or for marketing purposes.
(initial)

I have read the foregoing and fully understand the contents thereof.

____
(patient signature or legal guardian if minor)

____
(witness signature)

____
(legal guardian relationship to patient if minor)

____
(patient address)

____

Pharmacy Authorization

Dated: ___________________________

In order to maintain accurate medication records and history, we are requesting authorization to access your medication history. Please notate your pharmacy information below:

____ ___________________
Pharmacy Name and Location Phone

____ ___________________
Pharmacy Name and Location Phone

____ ___________________
Pharmacy Name and Location Phone

I, _____________________________________(patient's name) hereby give ***CBBC Center For Hair Restoration*** authorization to access my medication history for the purpose of maintaining accurate medication records and history.

This authorization will remain in effect as long as I am an active patient under the care of Dr. Christine Stiles.

I may terminate the authorization at any time with a written request.

____
(patient signature or legal guardian if minor)

______________________________________ ______________________________________
(witness signature) (legal guardian relationship to patient if minor)

____
(patient name printed)

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HAIR RESTORATION

HIPPA Privacy Rule

In effort to comply with the Privacy Rule to implement the requirement of the Health Insurance Portability & Accountability Act of 1996 (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please circle your response to the following:

May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answers your calls? YES NO N/A

May we leave messages on a voice mail at work/home regarding an appointment, referral or test results?
YES NO N/A

May we discuss your appointments/treatments with your spouse? YES NO N/A

May we discuss your appointments/treatments with your children or other family members? Please list names: ______________________________
____
YES NO N/A

May we share your pertinent medical information with specialists you may be seeing? YES NO N/A

Request for Electronic Communication:

I request that the following communications from the practice be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk, and will not hold the practice responsible should such incident occur.

Communications: ____ Appointment Reminders ____ Prescription Refill Reminders

____ Other (list specifically) ______________________________

Method: ____ Email: ______________________________

____ Text - Phone Number: ______________________________

Acknowledgment and Agreements:
I understand and agree that the requested communication method is not secure, making PHI (Private Health Information) at risk for receipt by unauthorized individuals. I accept the risk and will not retaliate against the practice in any way should this occur.

You must inform us, in writing, of any changes in your directives. This record takes effect immediately and will be kept in your file along with acknowledgement of Receipt of Your Notice of Privacy Practices.

______________________________ ____________
Patient Signature Date

______________________________ ____________
Witness Date

Print name: ______________________________ Phone No.: ______________________________

Address: ______________________________

Personal Representative: ______________________________ Request Received By Date: ____________

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HAIR RESTORATION

Smoking Risk Acknowledgement

In an effort to fully inform our patients on the risks of smoking associated with healing & surgery, we require all prospective patients to read the following statements and initial each line confirming that they received this information and understand it.

I have advised my physician that (please initial one):

______ I do not smoke and have never smoked in the past.
______ I currently smoke or have smoked in the recent past.
______ I am not currently smoking, but have smoked in the past.

All patients must read the following statements and initial each line.

______ I understand that I may not smoke six (6) weeks before my procedure.
______ I understand that exposure to second-hand smoke is just as harmful to me as if I smoked myself.
______ I understand that smoking six (6) weeks prior to surgery and ANY smoking following surgery greatly increases the risk of postoperative complications.
Possible complications include:

- Blood clots
- Death of skin or tissue requiring additional surgery
- Delayed wound healing
- Unfavorable scars
- Increased risk of infection
- Decreased graft take

______ If I currently smoke, I understand that I will be tested for continine, a byproduct of nicotine, at my pre-operative visit approximately two (2) weeks before my surgery. I understand my surgery will be rescheduled for a positive test.
______ I understand that a positive test will cause the cancellation of my surgery and may lead to forfeiture of 50% of my surgeon's fees.
______ I understand that the use of nicotine post operatively will impact the longevity of my results. I will be responsible for all fees associated with all revisions that may be necessary.

____ ____________
Patient Signature Date

____ ______ ____________
Witness Date