Garlich
Facial Plastic Surgery

Paul Garlich, M.D.

CONSULTATION AND MEDICAL HISTORY

PATIENT _____ **DATE** _____
First Middle Last

Preferred name to be addressed by the office staff: _____

Phone Numbers

Home: _____ Work _____ Cell _____

Fax Number: _____ E-mail _____
(If you do not wish to receive email from Northeast Georgia Otolaryngology and Garlich Facial Plastics DO NOT give email address)

Emergency Contact: _____ Emergency Phone: _____

Addresses

Primary Address:

_____
Street Apt#

_____
City, State, Zip

Secondary Address:

_____
Street Apt#

_____
City, State, Zip

Additional Information

Date of Birth: _____ Age_____ Sex: M / F

Social Security: _____ Marital Status M / D / S / W / Separated

Spouse's Name: _____

How did you hear about Garlich Facial Plastics?: _____

Which of the following procedures interest you? (Please Circle)

Botox	Cheek Implants	Chemical Peel	Chin Implant	Eyelids
Face or Neck Lift	Forehead Lift	Hair Transplants	Lip Augmentation	Ears
Injectable Fillers	Rhinoplasty (nose)	Scar Revision	Removal, Cysts, Warts, Moles, etc.	

Have you consulted other physicians concerning this? YES / NO

Is having surgery your idea or someone else's? (please explain): _____

Why have you decided to have surgery at this time? _____

Primary Care Physician: _____
Name Phone

When/Where did you last have the following? _____

Physical Exam: _____ EKG _____

Blood Work: _____ Chest X-ray _____

MEDICAL AND SURGICAL HISTORY (Page 2 of 3)

Gynecological History

Date of last menstrual period: _____ Date of last gynecological exam: _____

Do you take oral contraceptives or hormone replacements? _____

Date of last mammogram: _____ Number of pregnancies _____

Cosmetic History - Please list all COSMETIC surgeries and the SURGEONS who performed them

	NAME OF PROCEDURE	NAME OF SURGEON	DATE
1			
2			
3			

Describe your history of:

Sun exposure _____ Skin Cancer _____ Acne _____

Have you ever used Accutane treatment for your skin? _____ When? _____

Other skin problems: _____

Surgical History

Please list all NON-COSMETIC surgeries only.

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____

Please list any other hospitalizations and reasons for treatment.

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____

Any ANESTHESIA problems in the past? _____
Family problems with anesthesia? _____

Other

Current weight _____ Ideal weight _____ Height _____

Do you exercise regularly? YES / NO If yes, what form and how often ? _____

Have you ever smoked? YES / NO If yes, do you still smoke? YES / NO

At what age did you start? _____ At what age did you stop? _____ How many packs per day? _____

Do you drink alcohol? YES / NO How many drinks per day? _____ Per week? _____

Do you have bleeding or bruising problems? _____
Do you have high blood pressure? _____ What is your normal BP? _____
Do you have any other heart problems? _____
Do you have any lung problems (asthma, emphysema)? _____
Do you have any other health problems (arthritis, back problems, diabetes, seizures, strokes, etc.)? Describe below: _____

_____
Have you ever been treated for a psychiatric illness? _____
Do you wear dentures/retainer, do you have caps or a bridge? _____
Do you have or have you been treated for cancer? _____ Where? _____
Do you wear glasses? YES / NO Do you wear contacts? YES/ NO

MEDICAL AND SURGICAL HISTORY (Page 3 of 4)

YES	NO		YES	NO	
___	___	Hives	___	___	Hair Loss
___	___	High Blood Pressure	___	___	Seizures
___	___	Heart Disease	___	___	Aspirin Products
___	___	Tuberculosis	___	___	Hepatitis
___	___	Diabetes	___	___	Drug allergies or sensitivity
___	___	Psoriasis	___	___	Local anesthetic sensitivity
___	___	Hay Fever	___	___	Asthma
___	___	Excema	___	___	Keloids (raised scars)
___	___	Herpes	___	___	Are you pregnant?
___	___	Tested for HIV	___	___	Skin Cancer
___	___	Headaches	___	___	Kidney or thyroid problems(circle please)

Do you have any other health problems? Describe: _____

Family History

Family History of:

Diabetes? _____ Heart disease? _____

Arthritis? _____ Lung problems? _____

Stroke? _____ Bleeding disorders? _____

Kidney problems? _____ Liver problems? _____

Other disorders? _____

Medications

Please list all CURRENT or RECENT medications, frequency and reason for taking them (over-the-counter and prescription medications please).

1_____

2_____

3_____

Aspirin or ibuprofen products, arthritis medications? YES / NO Vitamins or herbal supplements YES / NO

Please list any allergies or reactions to medications.

1_____

2_____

3_____

Do you have any other allergies? (Food, Latex) _____

BY SIGNING THIS FORM, I ATTEST THAT THE ABOVE MEDICAL INFORMATION IS ACCURATE, AND I HAVE DISCLOSED ALL INFORMATION HONESTLY.

Payment is expected at the time of service. We accept cash, check or credit card (Visa, Mastercard, Discover and American Express). In the event insurance covers my procedure, I authorize the release of any information necessary to process claims and direct payment to myself or the doctor who accepts assignment.

Signature _____ **Date** _____

I understand the under the Health Insurance Portability & Accountability Act of 1996 that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that t treatment directly and indirectly;

Obtain payment from third-party payers: and

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy Practices attached. I understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy.

Signature _____ **Date** _____

EFFECTIVE DATE APRIL 1, 2008

GARLICH FACIAL PLASTICS
A DIVISION OF NORTHEAST GEORGIA OTOLARYNGOLOGY
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Aspire Facial Rejuvenation Center's, Privacy Officer, Donna Simmons, at 678-343-2190. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.