Tony L. Weaver, DO

Dear Patient,

We would like to take this opportunity to thank you for choosing HH Plastic & Reconstructive Surgery for your health care needs and to welcome you to our office. We are pleased that you have chosen us to provide you with medical services.

Our website *(hhplasticsurgery.org)* should help answer any questions you have about our office. We want you to know about our office services and what to expect at the time of your first visit.

Please complete the enclosed forms prior to your appointment. Please bring them with you on your appointment date, along with your identification cards, insurance cards and medication list, as well as your co-payments and/or deductibles.

If you are unable to keep this appointment or if you are going to be more than **15 minutes** late, please call our office at (256) 265-6851 as soon as possible. We will be happy to reschedule a more convenient time for you.

We look forward to seeing you and if you have any questions, please do not hesitate to call our office.

Sincerely,

Tony L. Weaver, MD
HH Plastic & Reconstructive Surgery

401 Lowell Drive, Ste. 12
Huntsville, AL 35801
o: (256) 265-6851
f: (256) 265-6869

NONSURGICAL PATIENT PACKET

Plastic & Reconstructive Surgery

Date: ____________________________

Name	Date of Birth

Address

Home Phone	Business Phone	Cell Phone

Please check your preferred contact phone: ☐ Home ☐ Business ☐ Cell

Email

Marital Status ☐ Single ☐ Married, anniversary date:

Employer	Occupation

Does your job require you to work outdoors? ☐ Yes ☐ No

Referred by	Primary Care Provider

What would you like to achieve from your treatment today?

YOUR SKIN CARE

Have you ever had a facial treatment? ☐ No ☐ Yes

Have you ever had a facial surgery? ☐ No ☐ Yes, describe: ____________________

Have you ever had a hypertrophic scar or keloid? ☐ No ☐ Yes, describe: ____________________

Have you ever had a body spa treatment?

☐ No ☐ Yes, date: ____________________

Check all that apply: ☐ Massage ☐ Salt glow ☐ Seaweed wrap ☐ Moor mud

☐ Body scrub ☐ Other: ____________________

Check the one that best describes your skin type:

- ☐ Creamy complexion (always burns easily, never tans)
- ☐ Light complexion (always burns, tans slightly)
- ☐ Light/matte complexion (burns moderately, tans gradually)
- ☐ Matte complexion (seldom burns, always tans well)
- ☐ Brown complexion (rarely burns, deep tan)
- ☐ Black complexion (never burns, deeply pigmented)

Do you have any special skin problems or concerns pertaining to your face or body?

☐ No ☐ Yes, describe: ______________________________

Have you ever had chemical peels, laser or microdermabrasion? ☐ No ☐ Yes:

Was this in the last month: ☐ No ☐ Yes

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/Vitamin A derivative products?

☐ No ☐ Yes, describe: ______________________________

Check and describe the products you have used in the last three months:

☐ Soap ______________________________

☐ Toner ______________________________

☐ Mask ______________________________

☐ Eye product ______________________________

☐ Cleanser ______________________________

☐ Day moisturizer ______________________________

☐ Exfoliator ______________________________

☐ Scrub ______________________________

☐ Shower gel ______________________________

☐ Body lotion ______________________________

☐ Sunscreen ______________________________, SPF: ________

☐ Night moisturizer/cream ______________________________

☐ Makeup products ______________________________

____

☐ Other ______________________________

____

Have you used an acne mediation? ☐ No ☐ Yes, when: ________________ describe: ______________________________

What skin care products are you currently using? (list brand where known)

____

____

____

Have you recently used any self-tanning lotions, creams or treatments?

☐ No ☐ Yes, describe: ______________________________

Have you experienced Botox, Restylan, Collagen or other filler injections?

☐ No ☐ Yes, describe: ______________________________ Date of last injection:______________________________

Check any of the following hair removal methods you have used in the past six weeks:

☐ Shaving ☐ Electrolysis ☐ Tweezing ☐ Depilatories ☐ Waxing ☐ Plucking ☐ Stringing

☐ Haven't used any of these in the past six weeks

Check any of the areas of concern you have and explain:

Regarding your **SKIN:**

☐ Breakouts/acne ______________________________

☐ Blackheads/whiteheads ______________________________

☐ Excessive oil/shine ______________________________

☐ Rosacea ______________________________

☐ Broken capillaries ______________________________

☐ Redness/ruddiness ______________________________

☐ Sun spot/liver spot/brown spot ______________________________

☐ Uneven skin tone ______________________________

☐ Sun damage ______________________________

☐ Wrinkles/fine lines ______________________________

☐ Dull/dry skin ______________________________

☐ Flaky skin ______________________________

☐ Dehydrated ______________________________

☐ Other ______________________________

Regarding your **EYES:**

☐ Dehydrated ______________________________

☐ Wrinkles ______________________________

☐ Puffiness ______________________________

☐ Dark circles ______________________________

☐ Other ______________________________

Regarding your **LIPS:**

☐ Dehydrated ______________________________

☐ Cracked/chapped lips ______________________________

☐ Other ______________________________

Check any that you have had an allergic reaction to and explain:

- ☐ Cosmetics ____________
- ☐ Medicine ____________
- ☐ Food ____________
- ☐ Animals ____________
- ☐ Sunscreen ____________
- ☐ Iodine ____________
- ☐ Pollen ____________
- ☐ AHAs ____________
- ☐ Fragrance ____________
- ☐ Shellfish ____________
- ☐ Latex ____________
- ☐ Drugs ____________
- ☐ Other ____________

What SPF do you use on your face? ________ How often/when? ____________

What SPF do you use on your body? ________ How often/when? ____________

Have you had any recent tanning bed or sun exposure that changed the color of your skin?

☐ No ☐ Yes, describe: ____________

FEMALES ONLY

Are you taking oral contraceptives? ☐ No ☐ Yes, specify: ____________

Any recent changes to or from your contraceptive treatment?

☐ No ☐ Yes, describe: ____________

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

Are you lactating? ☐ No ☐ Yes

Any menopause problems?

☐ No ☐ Yes, describe: ____________

Are you undergoing any hormone replacement therapy?

☐ No ☐ Yes, describe: ____________

MALES ONLY

What is your current shaving system? ☐ Wet shave ☐ Electric

Do you experience irritation from shaving? ☐ No ☐ Yes Ingrown hairs? ☐ No ☐ Yes

Are you interested in hair restoration? ☐ No ☐ Yes

Have you had prior treatment for hair loss? ☐ No ☐ Yes, describe: ____________

ADDITIONAL COMMENTS

Please use this space to complete answers where space above was insufficient (include question number):

____

____

____

FUTURE APPOINTMENTS/CONTACTS

Do we have permission to call your home, work or cell phone to confirm future appointments? ☐ No ☐ Yes

Do we have permission to contact you via mail/email about future promotions and news? ☐ No ☐ Yes

AGREEMENT

I understand, have read and completed this questionnaire truthfully to the best of my knowledge. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding any information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professionals from liability and assume full responsibility thereof.

Client signature	Date

List all medications, including over-the-counter and herbal medications:

Drug	Dose	Last Dose	Route	How Often	Reason

PATIENT INFORMATION

Plastic & Reconstructive Surgery

Name	Today's Date

Address

Home Phone	Business Phone	Cell Phone

Please check your preferred contact phone: ☐ Home ☐ Business ☐ Cell

SSN	Sex ☐ Female ☐ Male	Age	Date of Birth

Email

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer	Occupation

Employer Address

Referred by (physician)	Phone

Primary Care Provider	Phone

Result of on-the-job injury? ☐ Yes ☐ No	Result of accident? ☐ Yes ☐ No	Date of injury

SPOUSE/ACCOUNT GUARANTOR INFORMATION *Provide Account Guarantor information if patient is a minor*

Name	Date of Birth

SSN	Phone

Employer	Occupation

IN CASE OF EMERGENCY, CONTACT

Name	Relationship

Cell Phone	Alternate Phone (home/work)

INSURANCE INFORMATION *Provide Account Guarantor information if patient is a minor*

PRIMARY INSURANCE

Insurance Name	Relationship to Patient
Subscriber's Name	Copay Amount
Subscriber ID/Contract/Policy #	Group #
Subscriber's SSN	Subscriber's Date of Birth
Subscriber's Employer	Employer's Phone

SECONDARY INSURANCE

Insurance Name	Relationship to Patient
Subscriber's Name	Copay Amount
Subscriber ID/Contract/Policy #	Group #
Subscriber's SSN	Subscriber's Date of Birth
Subscriber's Employer	Employer's Phone

Person Responsible for this Account	Phone

When applicable, I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs or attorney's fees. I authorize HH Plastic & Reconstructive Surgery to release information to insurance carriers and for insurance carriers to release information to HH Plastic & Reconstructive Surgery concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignments applies.

Signature of Person Responsible	Today's Date	Time

HH Health System

101 Sivley Road • Huntsville, AL 35801 • 256-265-1000

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name ______________________________ SS Number (Optional)______________________________

Date of Birth ______________________________ Address ______________________________

Phone Number (_____)______________Date of Service______________ Patient Number

I authorize the use or disclosure of the above named individual's health information as described below:

1. Huntsville Hospital is authorized to make the disclosure.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

			Records Release Format
☐ Facesheet	☐ Physician Orders	☐ Laboratory Results	☐ e-delivery (Healthport Connect)
☐ Discharge Summary	☐ Outpatient Record	☐ Imaging Results	☐ CD
☐ History and Physical	☐ Emergency Dept. Record	☐ Bill / Claim Form	☐ Paper
☐ Operative Note	☐ EKG Report	☐ Itemized Statement	
☐ Pathology Report	☐ EBC Application	☐ Other____________________	
☐ Consultation Report	☐ Autopsy Report		
☐ Progress Notes			

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to, and used by, the following individual or organization:

   Name: ____

   Address: ____

5. For the purpose of ____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

   ____

   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

or

I understand that if I refuse to sign this form, under specific conditions the organization can refuse:

Treatment   Enrollment in the health plan   Eligibility for benefits

______________________________ ______________ ______________
SIGNATURE DATE TIME

______________________________ ______________________ __________ __________
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS DATE TIME

ROI132

HUNTSVILLE HOSPITAL Medical District