J Gonzalez, MD Aesthetic Surgery
F. Jorge Gonzalez, MD

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: _____ Secondary Phone #: _____

DOB: _____ Age: _____ Sex: _____ SSN: _____

Email Address: _____

Who is your primary care physician and when was your last visit? _____

Preferred Pharmacy (name and phone number): _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____

Consent to Communicate: Please mark the ways that you consent to us communicating with you

Method	OK to leave Voicemail?	OK to Leave Message with Another Person?	Pick a Preferred Contact Method(s)	Best Time to Call
☐ Call Home Phone	☐ Yes	☐ Yes	☐ Home Phone	_____
☐ Call Cell Phone	☐ Yes	☐ Yes	☐ Cell Phone	_____

☐ Send Text Message ☐ Text Appointment Reminders ☐ Text Medical/ Schedule Info

Patient's Signature: _____ Date: _____

Health History

Name: _____ DOB: _____

Section I: Surgery and Anesthesia History

Have you had any surgery before? ☐ Yes ☐ No
If yes, Please List: _____
Have you had any serious injuries or accidents before? ☐ Yes ☐ No
If yes, Please List: _____
Do you or anyone in your family have anesthesia complications? ☐ Yes ☐ No
If yes, Please Describe: _____

Section II: Specific Medical History

Height: _____ **Weight**: _____ **BMI (office use)**: _____

Do you have a history of the following?

	Yes	No		Yes	No
Anemia	☐	☐	Bronchitis	☐	☐
Asthma	☐	☐	Migraine Headaches	☐	☐
Lung Disease	☐	☐	Periodontal Disease	☐	☐
Bleeding Tendency	☐	☐	Stroke	☐	☐
Blood Clots	☐	☐	Thyroid Disease	☐	☐
Cancer	☐	☐	Pneumonia	☐	☐
Diabetes	☐	☐	Tuberculosis	☐	☐
High Blood Pressure	☐	☐	Stomach Ulcer	☐	☐
Heart Disease	☐	☐	Back Problems	☐	☐
Hepatitis	☐	☐	Leukemia	☐	☐
Herpes/Cold Sores	☐	☐	HIV Positive	☐	☐
Kidney Disease	☐	☐	Have you taken steroids?	☐	☐
Epilepsy or Seizures	☐	☐	Heart Attack	☐	☐
Depression, Anxiety, Psychosis	☐	☐	Have you had blood transfusion?	☐	☐
Have you been advised to or had psychiatric care?	☐	☐			

Others Not Listed: _____

Section III: Social History

	Yes	No	If yes, how much/often?
1. Do you smoke?	☐	☐	_____
2. Do you drink?	☐	☐	_____
3. Have you gained or lost weight in the past year?	☐	☐	_____

Section IV: Family History

1. Is your mother living? ☐ Yes ☐ No
   If no, List age and cause of death: _____
2. Is your father living? ☐ Yes ☐ No
   If no, List age and cause of death: _____

3. Are your siblings healthy? ☐ Yes ☐ No
   If no, please explain: _____
4. Do you have a family history of Breast Cancer? ☐ Yes ☐ No If yes, Who? _____

Section V: Medications

1. Have you been sick in the last month? ☐ Yes ☐ No If yes, explain: _____

List any medications, and oral or topical vitamins, herbal or dietary supplements you are taking:

Name of Medication	Strength	How many times a day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section VI: Allergies and Sensitivities to Medications Only

List all allergies and sensitivities:

Allergy:	**Severity:**	**Reaction:**
	☐ Mild ☐ Moderate ☐ Severe	
	☐ Mild ☐ Moderate ☐ Severe	
	☐ Mild ☐ Moderate ☐ Severe	
	☐ Mild ☐ Moderate ☐ Severe	
	☐ Mild ☐ Moderate ☐ Severe	

1. Are you allergic to medical adhesives such as tape, steri-trips, Band-Aids, latex or any other?
   ☐ No ☐ Yes If yes, please list: _____

Section VII: Women Only

1. Date of last mammogram: _____ 2. Number of Pregnancies: _____
3. Do you have regular breast self-exams? ☐ Yes ☐ No
4. Do you breast feed? ☐ Yes ☐ No
5. Breast lump or discharge? ☐ Yes ☐ No
6. Are you pregnant or trying to get pregnant? ☐ Yes ☐ No
7. Are you on birth control pills or hormone replacement therapy? ☐ Yes ☐ No

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

Consent for Purposes of Treatment, Payment And Healthcare Operations (HIPAA)

I, _____, consent to the use or disclosure of my protected health information by **Le Contour Aesthetic Surgery (F. Jorge Gonzalez, MD)** for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of **Le Contour Aesthetic Surgery (F. Jorge Gonzalez)**. I understand that diagnosis or treatment of me by (**Le Contour Aesthetic Surgery and F. Jorge Gonzalez, MD)** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Le Contour (F. Jorge Gonzalez, MD)** is not required to agree to the restrictions that I may request. However, if **Le Contour (F. Jorge Gonzalez MD)** agrees to a restriction that I request, the restriction is binding on **Le Contour (F. Jorge Gonzalez)**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Le Contour (F. Jorge Gonzalez MD))** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a medical insurance provider, or my employer. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I authorize **Le Contour (F. Jorge Gonzalez MD)** to communicate with my physicians.

I understand I have a right to review **Le Contour (F. Jorge Gonzalez MD)'s** "Notice of Privacy Practices" prior to signing this document. The **Le Contour (F. Jorge Gonzalez MD)** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operation of the **Le Contour (F. Jorge Gonzalez MD)**. The Notice of Privacy Practices for **Le Contour (F. Jorge Gonzalez MD)** is provided at **Le Contour (F. Jorge Gonzalez MD)**. This Notice of Privacy Practices also describes my rights and **Le Contour (F. Jorge Gonzalez MD)'s** duties with respect to my protected health information.

Le Contour (F. Jorge Gonzalez MD), reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy t be sent in the mail or asking for one at the time of my next appointment.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

_____ _____

Print Name Date

_____ _____

Patient Signature Witness

GONZALEZ MD
AESTHETIC SURGERY

Patient Photograph Release Form

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of **Le Contour Aesthetic Surgery** Staff. Any photographs taken will become part of my medical records. My photographs are to be used for the purposes of the office and medical chart. I hereby and authorize **Le Contour Aesthetic Surgery** and staff to take my photos and use them only for my surgery record with **Dr. Jorge Gonzalez**. I understand these photos will not be used on the office website or in any publications.

I authorize/allow **Le Contour Aesthetic Surgery** to take photos the day of my Consultation.

Patient's Name: _____

Patient's Signature: _____ Date: _____

GONZALEZ MD
AESTHETIC SURGERY

Authorization to Release Information

Many of our patients allow family members such as their spouse, parents or others to be present during their consultation. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have family members (spouse, parents or others) during your consultation with **Dr. Gonzalez**, you must sign this form. Signing this form will only give consent to release information to the family members indicated below. This consent form will not allow **Le Contour Aesthetic Surgery** to release any other information to these family members.

I authorize/allow **Le Contour Aesthetic Surgery** to release my information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Patient Name: _____

Patient Signature: _____ Date: _____

2019 Novel Coronavirus Screening 2020 Questionnaire

Patient/Visitor Name: _____ DOB:_____

Please circle YES or NO to the following questions:

1.) Have **you and/or anyone accompanying you today** traveled outside the U.S.A in the last 14 days?

YES NO

2.) Have **you and/or anyone accompanying you today** been in close contact with a person known to have 2019 Novel Coronavirus?

YES NO

3.) Do you **and/or anyone accompanying you today** currently have a fever or any respiratory symptoms such as a cough or shortness of breath?

YES NO

If answered yes to any of the above:

Name of person: _____ Phone #: _____

Dates of Travel & Location: _____

Signature of person completing this questionnaire: _____

Relationship to patient/minor (if applicable): _____ Date:_____

Nurse Assessment: _____

Temp: _____ Additional Vitals (if needed): _____

Additional Assessment needed? Yes / No

_____

Nurse: _____ Date/Time: _____