grossman plastic surgery
john a. grossman, m.d.
philippe a. capraro, m.d.

4600 hale parkway suite 100
denver, colorado 80220
phone: 303-320-5566 or 800-394-0010
fax: 303-320-1453

patient information

date: _____

surgeon: ☐ john a. grossman, m.d. ☐ philippe a. capraro, m.d.

name: _____ social security #: _____

street address: _____ email: _____

city: _____ state: _____ zip: _____

home phone: _____ work phone: _____ cell phone: _____

may we contact you: at home? y / n at work? y / n on your cell? y / n by email? y / n

date of birth: _____ age: _____ gender: ☐ f ☐ m marital status: ☐ m ☐ s ☐ d ☐ w

ethnicity: ☐hispanic/latino ☐non hispanic/latino language: ☐english ☐spanish ☐other

race: ☐african american ☐caucasian ☐hispanic ☐asian ☐decline to provide

profession: _____ employer: _____

reason for consultation: _____

referred by: _____

do you intend to bill medical services to your insurance? ☐ yes ☐ no

please note: health insurance plans do not cover aesthetic surgery and procedures that are not considered medically necessary

responsible party

please complete the following if you intend to bill your insurance or if someone other than the patient is responsible for payment

name: _____ social security #: _____

date of birth: _____ relationship to patient: ☐ self ☐ spouse ☐ parent ☐ other _____

street address _____

city: _____ state: _____ zip: _____

home phone: _____ work phone: _____ cell phone: _____

employer: _____

health insurance plan: _____ phone #: _____

group policy #: _____ member id #: _____

emergency contact

name: _____ relationship: _____

street address: _____

city: _____ state: _____ zip: _____

home phone: _____ work phone: _____ cell phone: _____

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PATIENT HEALTH INFORMATION

NAME: _____ Today's Date: _____
Last First MI

Date of birth: _____ Age: _____ SEX: Male / Female

Primary Care Physician: _____ Phone number: _____

Street address: _____

City: _____ State:_____ Zip: _____

Referring Physician: _____ Phone number: _____

Street address: _____

City: _____ State:_____ Zip: _____

I. GENERAL

a. Specific reason(s) for which you are being seen (check all that apply):

☐ **Aesthetic Surgery**		☐ **Reconstructive Surgery**
☐ Face	☐ Small Breasts	☐ Breast Reconstruction
☐ Neck	☐ Large Breasts	☐ Skin Cancer/Lesion
☐ Brow	☐ Sagging Breasts	☐ Facial/Nasal/Ear Injury
☐ Eyes	☐ Excess Truncal Skin	☐ Scars
☐ Nose	☐ Abdomen	☐ Burn Injury
☐ Lips	☐ Lower Extremity	☐ Hand Injury
☐ Ears	☐ Buttocks	☐ Wound Care
☐ Wrinkles/Skin	☐ Liposuction	☐ ER Follow-up
	☐ Other _____	☐ Other _____

b. Have you seen other doctors for this reason? ☐**Yes** ☐**No**
If so, who? _____

c. Have you been previously treated for this problem? ☐**Yes** ☐**No**

d. If so, please indicate:

Year	Treatment/Procedure	Physician	Complications

II. PAST MEDICAL HISTORY

a. What is your present: Height: _____ Weight: _____

b. Please indicate if you HAVE or have HAD any of the following medical problems:

	HAVE	HAD	COMMENTS/TREATMENT
High Blood Pressure			
Heart or Circulatory problems (eg. Chest pain/Heart Attack/ High cholesterol)			
Respiratory problems (eg. Asthma/Pneumonia/ Shortness of breath)			
Gastrointestinal Problems (eg. Ulcer/Hernia/Reflux)			
Genitounrinary Problems (eg. Voiding problems/ Menstrual problems/Impotence/Kidney stones)			
Endocrine/Immune Problems (eg. Thyroid problems/ Diabetes/HIV/AIDS/Lupus)			
Bleeding Problems (eg. Easy bruising/Clots/ Anemia)			
Musculoskeletal Problems (eg. Arthritis/Weakness/ Fibromyalgia/Limited mobility/Numbness/Tingling)			
Cancer (please indicate type)			
Eye Problems (eg. Dry eyes/Glaucoma/Tearing)			
Nasal Problems (eg. Bleeding/Sinusitis/Difficulty breathing/Runny nose)			
Neurological/Emotional Problems (eg. Headaches/ Seizures/Depression)			

c. Please list any additional medical issues and any non-surgical hospitalizations or emergency room visits requiring treatment. (Please list additional problems on the last page.)

Year Problem Treating Physician

_____

_____

_____

III. PAST SURGICAL HISTORY

a. Have you ever had surgery, including *Plastic Surgery*? ☐**Yes** ☐**No**

b. If you have had Plastic Surgery, please rate your results:

☐Excellent ☐Good ☐Fair ☐Poor

c. If your results were fair or poor, please describe briefly.

_____

_____

d. Please list all prior surgical procedures. (This includes removal of tonsils/appendix/gallbladder, LASIK surgery, wisdom tooth extraction, etc.) List additional surgeries on the last page.

Year	Procedure	Surgeon	Complications

e. If you have had surgery, check type(s) of anesthesia you received and circle any problem(s).

☐ General Anesthesia Nausea/Vomiting/Slow awakening/Difficult entubation/Other _____

☐ IV Sedation Nausea/Vomiting/Slow awakening/Other _____

☐ Epidural/Spinal Nausea/Vomiting/Insufficient/Bleeding/Headache/Other _____

☐ Block (eg. Axillary, regional, etc.) Insufficient /Prolonged/Systemic reaction Other _____

☐ Local Insufficient block/Heart palpitations/Systemic reaction/Other _____

IV. MEDICATIONS

a. Do you require antibiotics prior to surgery? ☐**Yes** ☐**No**

If so, why? _____

b. Do you take any medications <u>including vitamins</u>? ☐**Yes** ☐**No**

c. If so, please indicate.

	Name	Dose
☐ Blood pressure pills		
☐ Water pills		
☐ Blood thinners		
☐ Steroids		
☐ Insulin		
☐ Hormone replacement therapy		
☐ Vitamins (eg. B, C, E, K, etc.)		

d. Please list ALL additional medications that you take. List additional medications on the last page.

Medication	Dose	Why?

e. Do you take any herbs, dietary supplements, or weight reduction products? ☐**Yes** ☐**No**
If so, please circle.

Echinacea	Ephedra ***(Ma Huang)***	Feverfew	Garlic	Gingko
Ginseng	Goldenseal	Kave-kava	Licorice	METABO-life
St. John's Wort	Saw palmetto	Valerian		

Others _____

f. Do you take aspirin or ibuprofen products? ☐**Yes** ☐**No**
If so, please indicate.

- ☐ Aspirin (ASA/Bayer/Ecotrin/Excedrin/Fiorinal/etc)
- ☐ Ibuprofen (eg. Advil/Motrin/etc)
- ☐ Non-steroidal anti-inflammatories (eg. Aleve/Anapro/Daypro/Toradol/etc)

Others _____

V. ALLERGIES & SENSITIVITIES

a. Medication Allergies or Sensitivities? ☐**Yes** ☐**No**
If so, please indicate drug and circle reaction(s).

- ☐ Penicillin Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____
- ☐ Sulfa Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____
- ☐ Morphine Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____
- ☐ Codeine Rash/Hives/Nausea/Vomiting/Anaphylaxis/Swelling/Other _____

Other Medication(s)	**Reaction**
_____	Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other _____
_____	Rash/Hives/Anaphylaxis/Swelling/Nausea/Vomiting/Other _____

b. Environmental or Food Allergies? ☐**Yes** ☐**No**

c. Latex Allergies? ☐**Yes** ☐**No**

d. Tape or Adhesive Sensitivities? ☐**Yes** ☐**No**
If so, please list type of tape or adhesive.

_____

VI. SOCIAL HISTORY

a. ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

b. Children (birth years): _____

c. Do you smoke?/Have you ever smoked? ☐**Yes** ☐**No**
If yes, please indicate and circle appropriate reply:

_____ Cig's or Packs/Day _____ x Years Quit _____ weeks/months/years ago

d. Do you drink alcohol? ____ times/Day ____ times/Week ____ Rarely _____ Never

f. Do you drink caffeinated beverages? ☐**Yes** ☐**No** If yes: _____/Day

g. Do you use any recreational drugs? ☐**Yes** ☐**No**

VII. FAMILY HISTORY

Do you have a family history of:			Relationship	Problem
Heart problems	☐**Yes**	☐**No**	_____	
Diabetes	☐**Yes**	☐**No**	_____	
Breast cancer	☐**Yes**	☐**No**	_____	
Other cancers	☐**Yes**	☐**No**	_____	
Bleeding problems	☐**Yes**	☐**No**	_____	
Anesthesia problems	☐**Yes**	☐**No**	_____	
Other problems	☐**Yes**	☐**No**	_____	

VIII. ADDITIONAL INFORMATION

_____

_____

_____

_____

_____

_____

_____

SIGNATURE: _____

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.

Grossman Plastic Surgery & Facial Aesthetics is required by law to maintain the privacy of your medical information and to provide you with notice of its legal duties and privacy practices with respect to your medical information.

Effective Date of This Notice: August 13, 2014

Grossman Plastic Surgery & Facial Aesthetics collects medical information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of Grossman Plastic Surgery & Facial Aesthetics but the information in the medical record belongs to you. Grossman Plastic Surgery & Facial Aesthetics protects the privacy of your health information. The law permits Grossman Plastic Surgery & Facial Aesthetics to use or disclose your health information for the following purposes:

Medical Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to staff members or other healthcare professionals. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment.

Payment. Your medical information may be used to seek payment from your health plan. For example your health plan may request and receive information on the dates of service, services provided and the medical condition being treated.

Health Care Operations. We may use and disclose medical information about you in the business aspects of running our practice. These uses and disclosures are necessary to of our Practice. These uses may include reviewing our treatment and services to evaluate the performance of our staff. We may also use or disclose information about you for internal and external utilization review and/or quality assurance; to business associates for the purposes of assisting us in compliance with our legal requirements; to auditors to verify our records; and to billing companies. We shall endeavor, at all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your medical records.

Reminders and Treatment Alternatives. We may contact you prior to your procedure to discuss a preoperative assessment and medication. Other reasons may include appointment reminders, treatment alternatives, or health-related benefits and services that may be of interest to you. This contact may be by phone, in writing, e-mail, or otherwise and may involve the leaving of a message on an answering machine or e-mail which could be potentially received or intercepted by others.

Notification and communication with family. We may disclose your medical information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

As Required by Law. We will disclose medical information about you when required to do so by federal, state and local law.

Public Health As required by law, we may disclose your medical information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health Oversight Activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

Judicial and Administrative Proceedings. We may disclose your medical information in the course of any administrative or judicial proceeding. We may also disclose medical information about you in response to a subpoena, discovery request, court order or other lawful process by someone else involved in the dispute.

Research. We may disclose your medical information to researchers conducting research that has been approved by an Institutional Review Board (IRB). For example for the use of a specific implant would require that your medical information be disclosed in order to meet the IRB requirement.

Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. These programs provide benefits for work-related injuries or illness.

When Grossman Plastic Surgery & Facial Aesthetics May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Grossman Plastic Surgery & Facial Aesthetics will not use or disclose your health information without your written authorization. If you do authorize Grossman Plastic Surgery to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Right to Request Restrictions. You have the right to request restrictions or limitations on certain uses and disclosures of your medical information. Grossman Plastic Surgery & Facial Aesthetics is not required to agree to the restriction that you requested. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Inspect. You have the right to inspect and copy your medical information. To inspect and copy your medical information, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge you a fee for the costs of copying and mailing. The Practice will act on your request within 30-60 days.

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 Grossman Plastic Surgery & Facial Aesthetics.
To request an amendment, your request must be in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request. The Practice will act on your request within 30-60 days.

Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your medical information made by Grossman Plastic Surgery & Facial Aesthetics except that Grossman Plastic Surgery & Facial Aesthetics does not have to account for the disclosures described relating to treatment, payment, health care operations, information provided to you, and certain government functions as listed in this Notice of Privacy Practices. The Practice will respond to your request within 30-60 days.

Right to a Paper Copy of This Notice. You have a right to a paper copy of this Notice of Privacy Practices. You may obtain a copy of this notice by contacting our office at 303-320-5566.

Right to Revise Privacy Practices. Grossman Plastic Surgery & Facial Aesthetics reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, Grossman Plastic Surgery & Facial Aesthetics is required by law to comply with this notice. We will post a copy of the current Notice in the office. The effective date of a revised Notice will be noted on its first page. In addition, each time

you visit Grossman Plastic Surgery & Facial Aesthetics for health care services or treatment, you may request a copy of the current Notice in effect.

Requests to Inspect Your Medical Information. As permitted by law, we require that requests to inspect or copy your medical information be submitted in writing. You may obtain a form to request access to your records by contacting our Privacy Officer at 303-320-5566.

Complaints. If you believe your privacy rights have been violated, you should direct the matter to our attention by sending a letter describing the cause of your concern. If you would like to submit a comment or complaint about our privacy practices, you may do so by sending a letter outlining your concerns. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person. You may contact our Privacy Officer regarding our duties and your rights under the privacy regulations. The Privacy Officer can provide information regarding this Notice by request. Complaints should be directed to:

Privacy Officer
Grossman Plastic Surgery & Facial Aesthetics
4600 Hale Parkway, Suite 100
Denver, CO 80220
303-320-5566

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You may also address your compliant to one of the regional Offices for Civil Rights. A list of these offices can be found online at http://www.hhs.gov/ocr/regmail.html.

GROSSMAN plastic surgery & facialaesthetics

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

I acknowledge and agree that I have been provided a copy of the Notice of Privacy Practices for

John A. Grossman, M.D., P.C., Grossman Plastic Surgery, Pamela Hill, Inc. and Facial Aesthetics that describes how my protected health information must be protected and my rights to access and control such information. I acknowledge and agree that I have reviewed the Notice of Privacy Practices in its entirety and been given the opportunity to ask any questions regarding the use or disclosure of my protected health information and my associated rights. I acknowledge and agree that I have had all my questions answered to my satisfaction.

_____ _____

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) **DATE**

_____

PRINTED NAME

_____

PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)

FOR OFFICE USE ONLY

WE WILL MAKE A GOOD FAITH EFFORT TO OBTAIN A WRITTEN ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE

OF PRIVACY PRACTICES PROVIDED TO EACH PATIENT. IF A PATIENT IS UNWILLING OR UNABLE TO SIGN THIS

ACKNOWLEDGMENT, THE GOOD FAITH EFFORTS TO OBTAIN SUCH ACKNOWLEDGMENT AND REASON WHY THE ACKNOWLEDGMENT WAS NOT OBTAINED MUST BE DOCUMENTED.

REASON:

grossman plastic surgery
john a. grossman, m.d.
philippe a. capraro, m.d.

4600 hale parkway suite 100
denver, colorado 80220
phone: 303-320-5566 or 800-394-0010
fax: 303-320-1453

photo consent

surgeon: ☐ john a. grossman, m.d. ☐ philippe a. capraro, m.d.

medical photo consent

I hereby give Grossman Plastic Surgery physicians and staff the absolute permission to photograph myself, for the medical reason (s) indicated at my consultation, and for pre and post operative care, only.

Name (please print) _____

Signature _____ Date _____

photo release

I hereby give Grossman Plastic Surgery physicians and staff the absolute right and permission to copyright and/or publish, or use photographic portraits of me, or in which I may be included in whole or in part, or reproductions thereof in color or otherwise, for presentations, photo albums, display on the company's web site, art trade, news or any other lawful purpose whatsoever. I hereby waive any right that I may have to inspect and/or approve the finished product or the advertising copy that may be used in connection therewith, or the use to which it may be applied.

Name (please print) _____

Signature _____ Date _____

Patient request re restricted use _____

*Staff comments*_____ *Date* _____

parent or guardian of a minor

I, the undersigned, being the parent or guardian of _____
do hereby consent and/or release of photos for the stated purpose above, and signature thereto.

Name (please print) _____

Signature _____ Date _____