SLENT
Facial Plastics & Medical Aesthetics

New Patient Information & Consents

Name: _____ DOB: _____ SSN: _____ Gender: ____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Other#: _____

Employment Status: _____ Occupation: _____ Email Address: _____

Marital Status: ☐ S ☐ M ☐ D ☐ W

How did you hear about our office?

- ☐ Patient Referral: _____
- ☐ Friend: _____
- ☐ Dr. Referral: _____
- ☐ Other: _____

Government Required Questions

Race:

☐ White ☐ Black/African American ☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ Other

Ethnicity:

☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Emergency Contact:

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Phone #: _____ Ok to Leave message? ☐ Yes ☐ No

Consent to Contact:

Method	Appointment Reminders	Office Specials
Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No
Text Message	☐ Yes ☐ No	☐ Yes ☐ No
Email	☐ Yes ☐ No	☐ Yes ☐ No

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Ace of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). 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 the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read, and understand *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* at any time and that I may contact this organization to obtain a current copy.

Signature: _____ **Date**: _____

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Primary Care Physician: _____

Pharmacy: _____

Name: _____

Age: _____

Reason for today's visit: _____

List daily medications and dosage: _____

_____

Allergies? _____

Prior surgeries? _____

_____

MEDICAL HISORY

Patient - please check the appropriate boxes below for any conditions you are *currently* experiencing.

		FAMILY HISTORY	
Condition	**Patient**	**Mother**	**Father**
Allergic rhinitis			
Anxiety			
Asthma			
Heart Condition*			
Lung Disease*			
Diabetes			
Hearing Loss			
Heartburn/Reflux			
High Blood Pressure			
Sleep Apnea			
Snoring			
Kidney Failure			
Sinusitis			
Stroke			
Smoking			
Anemia			
Depression			
Heart Attack			
Hypothyroidism			
Migraine			
Cancer*			
Other			

Previous Radiation

☐ Yes ☐ No

Prior Chemotherapy

☐ Yes ☐ No

Smoking Status

☐ Never

Current Smoker

☐ Yes ☐ No

Number of cigarettes/day: _____

How many years? _____

Former Smoker

☐ Yes ☐ No

Number of cigarettes /day: _____

How many years? _____

Quit Date: _____

Do you drink alcohol?

☐ Yes ☐ No

☐ Beer ☐ Wine ☐ Liquor

Number of drinks: _____

☐ daily ☐ weekly ☐ monthly ☐ yearly

Have you ever used illegal or IV drugs?

☐ Yes ☐ No

Type: _____

(985) 231-5301 office
(205) 623-1080 fax

1420 North Causeway Blvd
Mandeville, LA 70471

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Check the appropriate boxes for symptoms you are *currently* experiencing.

Eyes
☐ Pain ☐ Dry ☐ Watery/Itchy ☐ Vision loss ☐ Blurring/Double vision ☐ Discharge

Ear, Nose, Throat
☐ Ear Pain ☐ Hearing loss ☐ Ringing ☐ Dizzy ☐ Stuffy Nose ☐ Runny Nose
☐ Hoarseness ☐ Sore throat ☐ Trouble swallowing

Cardiovascular
☐ Chest Pain ☐ Palpitations ☐ Fainting ☐ Shortness of breath with activity
☐ Shortness of breath while resting ☐ Swelling in legs

Respiratory
☐ Cough ☐ Shortness of breath ☐ Excessive sputum ☐ Coughing up blood ☐ Wheezing

Gastrointestinal
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation

Genitourinary
☐ Pain urinating ☐ Waking up to urinate ☐ Blood in urine ☐ Discharge
☐ Trouble starting ☐ Trouble stopping ☐ Genital sores

Musculoskeletal
☐ Back pain ☐ Joint pain ☐ Joint swelling ☐ Muscle cramps ☐ Muscle weakness ☐ Stiffness

Skin
☐ Scarring ☐ Eczema ☐ Rashes ☐ Skin cancer ☐ Suspicious lesions

Neurologic
☐ Paralysis ☐ Focal loss of sensation ☐ Blackouts ☐ Seizures
☐ Restless legs ☐ Insomnia ☐ Sleep Apnea ☐ Snoring

Psychiatric
☐ Depression ☐ Anxiety ☐ Memory loss ☐ Mental disturbance ☐ Suicidal
☐ Hallucinations ☐ Paranoia

Endocrine
☐ Cold intolerance ☐ Heat intolerance ☐ Always thirsty ☐ Always hungry

HemeLymphatic
☐ Abnormal bruising ☐ Abnormal bleeding ☐ Enlarged lymph nodes ☐ Tender lymph nodes

Allergic/Immune
☐ Ocular allergies ☐ Nasal allergies ☐ Allergic dermatitis ☐ Recurring infections ☐ HIV exposure
☐ Immuno-compromised

Signature: _____ **Date:** _____
Patient or Legal Guardian

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Medical Records Request

Request for Protected Health Information (PHI)

Name: _____ DOB: _____

This request will expire on the following date _____ or in the event of _____. If date or event is not indicated, authorization will expire on January 1st the next calendar year.

I hereby request a copy of the sections of my medical record as indicated below to be forwarded to SLENT at fax number 205-623-1080.

- ☐ History and Physical Exam and Progress Notes
- ☐ Consultation Reports
- ☐ Hospital Operative/Discharge Summary
- ☐ Lab/Pathology Reports
- ☐ Radiology Reports: CT / MRI / X-Ray / Ultrasound / Etc.
- ☐ Other: _____

Patient Signature: _____ **Date:** _____

Please include this request as a coversheet when returning records.

Faxed to: _____ Fax Number: _____ Date:_____

From: _____Phone Number: 985-327-5905 Date: _____

***Warning**: This message is intended only for the person listed above. The attached information is confidential and considered privileged by law. If the reader of this fax is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you are not the intended recipient, please notify us and shred this information. Thank you for your cooperation.*

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