NEWPORT FACES
COSMETIC SURGERY

NEW PATIENT REGISTRATION

Fillable intake packet

PATIENT INFORMATION

Last Name **First Name**

Middle Initial **Preferred Name** **Date of Birth**

Age **Sex Assigned at Birth** **Gender Identity (optional)** **Pronouns (optional)**

Address

City **State** **ZIP Code** **Email Address**

Mobile Phone **Home Phone** **Work Phone** **Preferred Pharmacy**

Occupation **Employer**

Who may we thank for referring you?

CONTACT PREFERENCES

☐ Phone call ☐ Text/SMS ☐ Email ☐ Voicemail OK ☐ Detailed voicemail OK

EMERGENCY CONTACT

Last Name **First Name** **Relationship** **Mobile Phone**

RESPONSIBLE PARTY / GUARDIAN (IF DIFFERENT FROM PATIENT)

Name **Relationship** **Phone** **Date of Birth**

CONSENT FOR CONSULTATION / TREATMENT AND FINANCIAL RESPONSIBILITY

The above information is true and correct to the best of my knowledge. I give consent to Dr. Stephen H. Fink and Newport Faces Cosmetic Surgery to provide medical consultation and treatment as appropriate. I understand that separate procedure-specific informed consent may be required before any procedure. I understand I am responsible for charges incurred, including amounts not covered by insurance or financing.

Patient / Guardian Signature **Print Name** **Date**

NEWPORT FACES
COSMETIC SURGERY

PATIENT MEDICAL HISTORY

Please check Yes or No for each question

MEDICAL CONDITIONS AND RISK FACTORS

Are you pregnant or nursing?	Y	N	Liver insufficiency, cirrhosis, or active hepatitis?	Y	N
Are you currently undergoing radiation therapy or chemotherapy?	Y	N	Blood clots or pulmonary embolism?	Y	N
Connective tissue disorder such as Ehlers-Danlos syndrome, lupus, scleroderma, rheumatoid arthritis, Wegener disease, or sarcoidosis?	Y	N	Diabetes that requires medication?	Y	N
Surgery of the face or neck within the previous 6 months?	Y	N	High blood pressure or hypertension?	Y	N
Bleeding disorder?	Y	N	Heart disease or heart problems?	Y	N
Abnormal scarring, keloids, or poor wound healing?	Y	N	Pacemaker, AICD, implanted stimulator, or implanted medical device?	Y	N
Allergy or reaction to latex?	Y	N	Oxygen-dependent COPD or severe asthma?	Y	N
Lidocaine or local anesthetic allergy?	Y	N	Stroke or TIA?	Y	N
Epinephrine sensitivity?	Y	N	Current smoker, nicotine, vaping, or tobacco use?	Y	N
Prior parotidectomy or salivary gland removal?	Y	N	Do you consume alcohol? If yes, how often?	Y	N
Obstructive sleep apnea?	Y	N	Severe dry eyes?	Y	N
Are you currently under a pain contract?	Y	N	Medical marijuana use? If yes, how often?	Y	N
Kidney disease or dialysis?	Y	N	Seizure disorder or epilepsy?	Y	N
Immune suppression, transplant medication, or chronic steroid use?	Y	N	History of cold sores, herpes simplex, or shingles near treatment area?	Y	N
Use of blood thinners, aspirin, NSAIDs, fish oil, vitamin E, or supplements that may increase bleeding?	Y	N	Use of isotretinoin/Accutane within the past 12 months?	Y	N
Photosensitivity, light-triggered conditions, or photosensitizing medications?	Y	N	History of anesthesia problems, malignant hyperthermia, or severe nausea after anesthesia?	Y	N

For any Yes answer, please provide details on the next page.

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COSMETIC SURGERY

MEDICAL HISTORY DETAILS

Please provide complete details so the provider can review safely

DETAILS FOR YES ANSWERS

PREVIOUS SURGERIES / PROCEDURES

MEDICATIONS AND DOSAGES

ALLERGIES AND REACTIONS

PRIMARY PHYSICIAN / PHARMACY

Name of Physician

Physician Phone Number

Pharmacy Phone Number

OTHER HEALTH INFORMATION

I certify that all medical information I have listed above is accurate and complete to the best of my knowledge.

Patient / Guardian Signature

Print Name

Date

Provider Signature

Date

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CONSULTATION GOALS

This helps us understand your concerns and present appropriate options

REASON FOR VISIT

In your words, please describe the main reason for your visit today.

CONSULTATION PLANNING

Have you had or plan on having other consultations?

What was your overall experience from previous consultations?

When do you plan to have your surgical procedure?

What are your goals?

How long have you been considering this?

Are you working within a budget? If so, what are the financial parameters?

Are you interested in discussing Botox, fillers, or skincare?

ADDITIONAL NOTES

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PRIVACY AND COMMUNICATION ACKNOWLEDGMENTS

Keep a signed copy in the patient record

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I received, or was offered, Newport Faces Cosmetic Surgery's Notice of Privacy Practices. I understand that signing this acknowledgment does not mean I agree to any special use or disclosure of my health information, and I may request a paper copy of the notice at any time.

☐ I received the Notice of Privacy Practices. ☐ I was offered the notice but declined a copy.

Patient / Guardian Signature **Print Name** **Date**

PERMISSION TO DISCUSS CARE / BILLING WITH OTHERS

List any person(s) we may speak with about appointments, care coordination, billing, or general account questions.

Name	Relationship	Phone	Limits / Notes

Name	Relationship	Phone	Limits / Notes

ELECTRONIC COMMUNICATION CONSENT

I authorize the practice to contact me using the methods selected below for appointment reminders, scheduling, follow-up, clinical instructions, billing, and administrative messages. I understand that text messages and email may not be fully secure, and I may change my preferences in writing.

☐ Text/SMS OK ☐ Email OK ☐ Voicemail OK ☐ Do not text me

Patient / Guardian Signature **Print Name** **Date**

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PHOTO / VIDEO AND RECORDS AUTHORIZATION

Separate authorization for clinical documentation and optional marketing use

CLINICAL PHOTO / VIDEO CONSENT

I authorize Dr. Stephen H. Fink and Newport Faces Cosmetic Surgery to take photographs or videos for medical documentation, treatment planning, comparison, patient education within the practice, and continuity of care. These images may become part of my medical record.

☐ I authorize clinical photographs/videos for medical documentation.

Patient / Guardian Signature **Print Name** **Date**

OPTIONAL MARKETING / SOCIAL MEDIA PHOTO AND VIDEO AUTHORIZATION

This section is optional and separate from treatment. I understand that authorizing marketing, website, print, advertising, or social media use is not required to receive care. I may revoke this authorization in writing, but revocation will not apply to uses already made before the practice receives my written revocation.

☐ I DO authorize use of my photos/videos for website, social media, print, advertising, and patient education.

☐ I DO NOT authorize marketing, advertising, website, print, or social media use.

☐ Face may be shown ☐ Face must be hidden/cropped ☐ No name may be used

Patient / Guardian Signature **Print Name** **Date**

AUTHORIZATION TO REQUEST / RELEASE MEDICAL RECORDS (IF NEEDED)

I authorize the practice to request or receive medical records needed for my treatment and care from the provider/facility listed below. I understand I may revoke this authorization in writing except to the extent action has already been taken based on it.

Provider / Facility Name **Phone** **Fax / Email**

Records Requested / Purpose

Expiration Date or Event **Patient / Guardian Signature** **Date**