Peter J. Abramson, M.D.
Board Certified
American Board of Facial Plastic and Reconstructive Surgery

ABRAMSON Facial Plastic Surgery & Rejuvenation Center

Patient Profile

Welcome to Abramson Facial Plastic Surgery & Rejuvenation Center. Our goal is to provide you with the highest quality of care. The first step is to learn all we can about your medical history. Please assist us by taking a few moments to complete all pages of the form below. Our staff will be glad to help you if necessary. The care we give you can be no better than the information you provide.

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

Address: _____ Marital Status: S M D Other

City:_____ State:_____ Zip: _____ Home Phone: _____

Date of Birth: _____ Age: _____ Work Phone: _____

E Mail Address: _____ Cell Phone: _____

SS#: _____ Sex: Male Female

Race:_____ Ethnicity:_____

Patient Employment

Employer: _____

Phone: _____

Emergency Contact

Name: _____
Relation: _____
Phone: _____

Primary Insurance (if applicable)

Primary Insured Person
Name: _____
Date of Birth: _____
Insured SS#: _____
Insured Employer: _____

Insurance Carrier: _____
Insurance ID#: _____
Policy/Group#: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

How did you hear about our office?

- ☐ **Patient** Who? We would love to thank them _____
- ☐ **Magazine/Print Article** Which Magazine? _____
- ☐ **Internet**
- ☐ **Our website**
- ☐ **Other:**_____

Medical Profile

Name:_____ DOB:_____

What would you like to discuss with Dr. Abramson today?

_____

_____

What are your concerns?

- ☐ Shape of your nose
- ☐ Difficulty breathing through nose
- ☐ Shape of your ears
- ☐ Jowls
- ☐ Drooping Neck
- ☐ Wrinkles around eyes
- ☐ Frown lines between the eyes
- ☐ Cheek/Lip folds
- ☐ Vertical lines around lips
- ☐ Thin Lips
- ☐ Facial Vessels
- ☐ "Brown Spots"
- ☐ Acne Scars

What procedures are you interested in?

- ☐ Threadlift
- ☐ Facelift
- ☐ Necklift
- ☐ Endoscopic Browlift
- ☐ Cheeklift
- ☐ Eyelid Lift (Blepharoplasty)
- ☐ Nose Reshaping (Rhinoplasty)
- ☐ Botox
- ☐ Juvederm/Radiesse/Sculptra
- ☐ Hair Restoration
- ☐ Hair Removal
- ☐ Facials
- ☐ Peels
- ☐ Medical Skin Care Regimen

When did you begin to consider surgical correction? _____

Have you consulted other physicians with your concerns? **Yes** ☐ **No** ☐

Have you discussed this surgery with your family? **Yes** ☐ **No** ☐

Are they agreeable? **Yes** ☐ **No** ☐

Cosmetic History

Please list all cosmetic surgeries, the Surgeon who performed them and when they were performed.
Please list all facial treatments/chemical peels/laser procedures

Procedure	**Surgeon**	**Date**

_____

_____

_____

_____

_____

Have you ever had any injectable fillers? (Restylane, Juvederm, Radiesse, Radiance, Collagen, Cosmoderm/Cosmoplast, Silicone etc) **Yes** ☐ **No** ☐

If yes, please list:_____

When was your last injection and to what area? _____

Have you ever had a Botox injection? **Yes** ☐ **No** ☐

If yes, what area was treated and when was your last injection? _____

_____

Skin History

Name:_____ DOB:_____

What are your concerns?

- ☐ Acne Scarring
- ☐ Fine lines & wrinkles
- ☐ Pigmentation
- ☐ Sun Damage
- ☐ Clocked pores/blackheads
- ☐ Whiteheads
- ☐ Age spots
- ☐ Scars
- ☐ Acne
- ☐ Large pores
- ☐ Blotchy skin
- ☐ Melasma
- ☐ Saggy skin
- ☐ Dry skin
- ☐ Oily skin
- ☐ Sensitive skin
- ☐ Facial Vessels

What procedures are you interested in?

- ☐ Facial
- ☐ Deep pore cleansing facial treatment
- ☐ Chemical Peel
- ☐ Epidermal Leveling
- ☐ Microdermabrasion
- ☐ Corrective treatments for the neck & décolleté/chest
- ☐ Laser treatment
- ☐ Medical Skin Care Regimen
- ☐ Mineral Make up

When did you begin to consider Skin treatment correction? _____
Have you consulted other estheticians with your concerns? **Yes** ☐ **No** ☐

Please describe your history of the following:
Sun exposure:_____
Skin Cancer: _____
Acne: _____
Other skin problems: _____
Have you ever used Retin-A? **Yes** ☐ **No** ☐
If yes, are you still using it? **Yes** ☐ **No** ☐
How often and what dosage? _____
Have you ever been placed on Acutane? **Yes** ☐ **No** ☐
If yes are still on it? **Yes** ☐ **No** ☐
Have you ever used a hormonal or cellular skin cream? **Yes** ☐ **No** ☐
What other skin care products are you currently using? _____
_____

Would you like to have a skin evaluation with Lina Valiukaite, our Medical Esthetician? **Yes** ☐ **No** ☐

Review of Systems

Name:_____ DOB:_____

Please check yes for those below that apply to you, and no for those that do not apply

Nasal Obstruction	**Yes** ☐	**No** ☐	**Nasal discharge**	**Yes** ☐	**No** ☐
Post nasal drip	**Yes** ☐	**No** ☐	**Nosebleed**	**Yes** ☐	**No** ☐
Snoring	**Yes** ☐	**No** ☐	**Facial pain**	**Yes** ☐	**No** ☐
Fever/Chills	**Yes** ☐	**No** ☐	**Abdominal Pain**	**Yes** ☐	**No** ☐
Weight Loss	**Yes** ☐	**No** ☐	**Nausea/Vomiting**	**Yes** ☐	**No** ☐
Night Sweats	**Yes** ☐	**No** ☐	**Yellow/Jaundice**	**Yes** ☐	**No** ☐
Irritated eyes	**Yes** ☐	**No** ☐	**Diarrhea**	**Yes** ☐	**No** ☐
Chest pain	**Yes** ☐	**No** ☐	**Painful urination**	**Yes** ☐	**No** ☐
Irregular heartbeat	**Yes** ☐	**No** ☐	**Blood in urine**	**Yes** ☐	**No** ☐
Shortness of breath	**Yes** ☐	**No** ☐	**Swollen joints**	**Yes** ☐	**No** ☐
Wheezing	**Yes** ☐	**No** ☐	**Back pain**	**Yes** ☐	**No** ☐
Cough up blood	**Yes** ☐	**No** ☐	**Rash**	**Yes** ☐	**No** ☐
Itchy skin	**Yes** ☐	**No** ☐	**Weakness**	**Yes** ☐	**No** ☐
Shaking	**Yes** ☐	**No** ☐	**Fainting**	**Yes** ☐	**No** ☐
High stress	**Yes** ☐	**No** ☐	**Depression**	**Yes** ☐	**No** ☐
Mood swings	**Yes** ☐	**No** ☐	**Frequent thirst**	**Yes** ☐	**No** ☐
Anemia	**Yes** ☐	**No** ☐	**Bruise easily**	**Yes** ☐	**No** ☐
Prolonged bleeding	**Yes** ☐	**No** ☐	**HIV risk factors**	**Yes** ☐	**No** ☐

Past Medical History

Please check yes for those illnesses you have or have had in the past, and no for those you have never had

Glaucoma	**Yes** ☐	**No** ☐	**Reflux**	**Yes** ☐	**No** ☐
Cataract	**Yes** ☐	**No** ☐	**Hiatal Hernia**	**Yes** ☐	**No** ☐
Hepatitis A	**Yes** ☐	**No** ☐	**Hepatitis B**	**Yes** ☐	**No** ☐
Hepatitis C	**Yes** ☐	**No** ☐	**High blood pressure**	**Yes** ☐	**No** ☐
Past heart attack	**Yes** ☐	**No** ☐	**Fibromyalgia**	**Yes** ☐	**No** ☐
Past stroke	**Yes** ☐	**No** ☐	**Gout**	**Yes** ☐	**No** ☐
Block arteries	**Yes** ☐	**No** ☐	**Arthritis**	**Yes** ☐	**No** ☐
Heart failure	**Yes** ☐	**No** ☐	**Mitral Valve Prolapse**	**Yes** ☐	**No** ☐
Past bypass surgery	**Yes** ☐	**No** ☐	**Have a Pacemaker**	**Yes** ☐	**No** ☐
Past angioplasty	**Yes** ☐	**No** ☐	**Seizure disoreder**	**Yes** ☐	**No** ☐
Asthma	**Yes** ☐	**No** ☐	**Parkinson's disease**	**Yes** ☐	**No** ☐
Emphysema	**Yes** ☐	**No** ☐	**Tuberculosis**	**Yes** ☐	**No** ☐
Spinal Injury	**Yes** ☐	**No** ☐	**Head injury**	**Yes** ☐	**No** ☐
Pneumonia	**Yes** ☐	**No** ☐	**Meningitis**	**Yes** ☐	**No** ☐
HIV Positive	**Yes** ☐	**No** ☐	**Low thyroid**	**Yes** ☐	**No** ☐
Overactive thyroid	**Yes** ☐	**No** ☐	**Thyroid nodule**	**Yes** ☐	**No** ☐
Thyroid Cancer	**Yes** ☐	**No** ☐	**Diabetes**	**Yes** ☐	**No** ☐
Bleeding disorder	**Yes** ☐	**No** ☐	**Use Aspirin**	**Yes** ☐	**No** ☐
Use Coumadin	**Yes** ☐	**No** ☐	**Other**	**Yes** ☐	**No** ☐
			Please explain:_____		

Have you had a pneumonia vaccination? Yes____ No____ Date: _____

Do you ever get cold sores of fever blisters on your lips? Yes____ No____

Surgical History

Please list all non-cosmetic surgeries

Procedure **Date**

_____

_____

_____

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Name:_____ DOB:_____

Medications

Please list all medications you are currently taking and the dosage:

☐ **I Consent to ALL Electronic Prescription Transactions**

Pharmacy: _____ Phone:_____

Do you have any drug allergies? **Yes ☐ No Know Drug Allergies ☐**
If yes, please list the drug and the reaction you have had to it_____
_____
_____
Please list any other allergies _____

Have you ever been treated for a Psychiatric illness? **Yes ☐ No ☐**
If yes, who treated you? _____

Family History

Please check yes for those illnesses that are present in your immediate blood relatives (parents, children or siblings)

Heart attack / disease	**Yes ☐ No ☐**	High blood pressure	**Yes ☐ No ☐**	Hearing loss	**Yes ☐ No ☐**
Blocked arteries	**Yes ☐ No ☐**	Diabetes	**Yes ☐ No ☐**	Sickle cell / trait	**Yes ☐ No ☐**
Past stroke	**Yes ☐ No ☐**	Thyroid problems	**Yes ☐ No ☐**	Allergies	**Yes ☐ No ☐**
Bleeding problems	**Yes ☐ No ☐**	Cancer	**Yes ☐ No ☐**	Asthma	**Yes ☐ No ☐**

Other family illness: if yes, please list:_____
_____

Social History

What type of work /school do you do? _____
Who lives with you at home? _____

You smoke___ packs of cigarettes a day **or** you smoked __- packs per day, then quit__-years ago.
You consume ___ alcoholic beverages ☐ **per day** ☐ **per week** ☐ **month**
You consume ___ caffeine beverages per day
You consume ___ glasses of water per day
Is there a chance you may be pregnant? **Yes ☐ No ☐**

Height: _____ Weight:_____

_____ _____
Patient signature (Guardian if patient is a minor) **Date**

Patient Agreement for Communication

I understand that as a patient at Abramson Facial Plastic Surgery I may be contacted from time to time to confirm appointments, to be give special offers, etc.
I authorized Abramson Facial Plastic Surgery to contact me in the following ways:
(Please check those you authorize and provide the telephone number)

□ Home Phone _____ □ Voicemail OK
□ Work Phone _____□ Voicemail OK
□ Cell Phone _____ □ Voicemail OK
□ Email _____
□ Fax _____

I understand that Abramson Facial Plastic Surgery will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

_____ _____
Patient Name / Signature Date

Abramson Facial Plastic Surgery & Rejuvenation Center
5673 Peachtree Dunwoody Rd, Suite 140
Atlanta, GA 30342
404-297-1789

Affiliated with Ear, Nose and Throat of Georgia, LLC

CONSENT FOR PHOTOGRAPHS

I understand that photographs will be taken periodically throughout my treatments. These photographs will be used to monitor progress and other factors. I understand that failure to consent to these photos will give the provider (Peter J. Abramson, M.D. its successors) the right to decline my treatment.

I,_____ DO

I, _____ DO NOT

grant Peter J. Abramson, M.D. and its successors and assign the right to use photographs of me, in the following areas: (initial all/any for use)

_____Website for Consumers
_____Newsletter to be sent to patients
_____Practice brochures
_____Public relations material
_____Seminars
_____Patient before and after photo information sheets

_____Copy to patient of before and/or after photos at patient request. (This permits Peter J. Abramson, M.D. to send photos from your medical records to your primary address on file unless otherwise indicated by patient or patient's responsible party.)

I understand that by signing below, Peter J. Abramson, M.D. need not approach me again for authorization on these photos.

_____	_____
Patient Full Name – Please Print	Witness Full Name – Please Print
_____	_____
Patient Signature	Witness Signature
_____	_____
Date	Date

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Abramson Facial Plastic Surgery & Rejuvenation Center
Privacy Policy Acknowledgement Statement

I hereby acknowledge that I have been aware that Abramson Facial Plastic Surgery & Rejuvenation Center, has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient of Abramson Facial Plastic Surgery & Rejuvenation Center, I understand and acknowledge the following:

1. Abramson Facial Plastic Surgery & Rejuvenation Center has a privacy policy in effect in the office.

2. Abramson Facial Plastic Surgery & Rejuvenation Center has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room or similar common area with patient access.

3. Abramson Facial Plastic Surgery & Rejuvenation Center has made me aware, that as a patient I am entitled to a copy of this Privacy Policy if I desire a copy for my personal file.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the Privacy Policy implemented by Abramson Facial Plastic Surgery & Rejuvenation Center and have read and understand the acknowledgment form.

If you desire a copy of the Privacy Policy, please request one at this time.

____ No, do not want a copy but I acknowledge the Privacy Policy exists
____ Yes, I DO want a copy of the Privacy Policy.

_____ _____
Patient Name: Date:

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Financial Responsibility

Co-payments

All office visits require a co-payment from your insurance company. Exceptions may include post operative visits for a determined period of time for some surgical procedures. Some insurance plans require co-payments for post-operative visits.

Deductible

A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service. An office visit with our physicians will include a face-to-face encounter and evaluation. Generally, a co-payment is required for the visit. In addition, some services and ALL procedures performed in the office require the patient to meet their deductible before insurance pays benefits. If you have not met your deductible, you will be responsible for full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same as surgery to the insurance company, and are billed as surgery.

Diagnostic Procedure Consent

Your office visit today may include a scope being placed in your nose or throat. This is considered a diagnostic procedure, which will be coded to your insurance carrier as an INVASIVE OR SURGICAL PROCEDURE. Depending on the specifics of your particular policy, your insurance carrier will pay all, part, or none of the cost of this procedure. **It is the responsibility of you, the insured, to be aware of the limits of coverage of your policy prior to this procedure**. Any charges not covered by the insurance carrier will be the responsibility of the patient. By initialing this section you are acknowledging these terms. **YOU HAVE THE RIGHT TO REFUSE THE DIAGNOSTIC PROCEDURE.**

No Show

Patients who fail to show for their scheduled appointment, or did not notify the office **24 HRS PRIOR** to the appointment, shall be subject to a No Show charge. For a procedure, or surgery, we require notification **1 WEEK** prior to the appointment. These charges are as follows: $25 for missed appointments, $150 for office procedures, and $150 for surgery.

Guarantee of Payment for Services & Assignment of Benefits

It is the policy of the office that you must pay for services when rendered except in the cases of surgery. If this applies to you, we will file your claim and you will be expected to pay only the portion that is not covered by your insurance. If you have any questions, please ask about this before leaving the office.

In the event that any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. This includes all charges related to office visits, procedures performed, co-payments and deductibles. If this account is placed in collections, the undersigned agrees to pay the balance plus a $25 surcharge for collections.

I hereby authorize insurance benefits to be paid directly to the physician, and I am financially responsible for non-covered services. I also authorize the physician to release my medical information in the processing of this claim.

Insurance Coverage

I understand that my eligibility for coverage by _____ has not been verified at the time of my appointment, but I want to receive medical services from Dr. _____.

I am aware that when the insurance is finally verified, there is a disclaimer which states my insurance does not guarantee payment, even though I may be **eligible** for benefits at the time of service. If it is determined that I am not eligible for coverage or the medical services are not covered, I understand that I will be responsible for payment for all services provided.

Referral Waiver

I understand that if my insurance requires a referral for my visit, I am responsible for making sure that the referral is obtained from my primary care physician. I also understand that if the referral from the primary care physician's office is not received before/on the day of my appointment, I agree to pay for all services rendered on the day of the visit.

Our office offers the use of Care Credit for qualifying persons.

I voluntarily give consent for my medical treatment or my child's medical treatment to the providers at Ear Nose and Throat of Georgia, LLC. I fully understand that payment is required at the time of service and should my claims be filed to my insurance company, any unpaid balance is my responsibility. In the event that the physician files to my insurance, I authorize benefits to be paid directly to the physician.

_____	_____	_____
Patient Name or(Guardian if patient is a minor)	**Patient Signature (Guardian if patient is a minor)**	**Date**