David Alessi, M.D., F.A.C.S

Alessi Institute for Facial Plastic Surgery

Patient Registration

Today's Date: _____

Welcome to David Alessi, MD and Alessi Institute for Facial Plastic Surgery. As a new patient, please fill out the information found below to the best of your ability. Please answer these health and beauty related questions to help us design the ideal experience for you. *All information will remain confidential.*

Name: _____ **Birthday:** ____/____/_____ **Age:** ___
last first middle

Responsible Party (if minor): _____ **Height:** _____ **Weight:** _____

Mailing Address: _____

City: _____ **State/Country:** _____ **Zip:** _____

Social Security # _____ **Driver's Lic #** _____

Telephone: Home _____ **Work** _____ **Cell** _____

☐ I consent to receive health-related and appointment information via phone

Primary Email Address: _____ ☐ I would like to receive health-related information via email

Sex: ☐Female ☐Male **Marital Status:** ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Preferred method for leaving confidential medical information: ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email

Primary Physician Name _____ **Phone #** _____

Dentist Name _____ **Phone #** _____

Preferred Pharmacy _____ **Phone #** _____

EMERGENCY CONTACT

Name: _____ **Phone:** _____ **Relationship:** _____

INSURANCE

Primary Insurance Holder information: Name: _____ Date of Birth: _____

Name of Insurance Provider _____ Contract # _____ Group # _____

How did you hear about Dr. David Alessi?

☐ TV ☐ Internet ☐ Magazine ☐ Newspaper ☐ Radio ☐ Other _____ Referred by _____ ☐ patient

Patient Employed by: _____ **Spouse or Responsible Party Name:** _____

Address: _____ **Address:** _____

Occupation: _____ **Occupation:** _____ **Business Phone** _____

Dear Patient,

Thank you for choosing us as your health care provider. We are committed to provide you with the best medical care services. The following information is intended to Prevent uncertainties in regards to our financial policy. Our practice firmly believes that a good doctor-patient relationship is based upon understanding and good communications.

INSURANCE

We are **out of network with Medi-Cal, some EPO Plan and all HMO.** As a courtesy, our practice will review your coverage; estimate your insurance company payment, review your insurance form, and file your claim with your insurance carrier. You will be responsible for any portion of your bill which is denied or not paid by you Insurance carrier. Your insurance coverage is a contract between you and your insurance carrier. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to work together to resolve any insurance problem.

DEDUCTIBLE

Your deductible will be verified at the time of service and if you have not met your deductible, you are required to pay at the time of service. All Medicare patients have a yearly deductible of $_____. Payment of services which qualify toward the yearly deductible begin on January 1st and conclude on December 31st of each year. For example, if your yearly deductible is $200.00, you must first pay the initial $200.00 to satisfy your deductible. The discount you receive from your insurance company will be calculated when we receive the explanation of benefits for your service and any adjustments will be made at the time.

COPAYMENT

All copayments must be made at the time of service. In Network for _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS. I hereby authorize Dr. David M. Alessi., M.D., F.A.C.S., to furnish information to insurance carriers concerning this illness and the treatments I receive and I hereby irrevocably assign to the doctors all payments for medical services rendered. I understand I am financially responsible for all charges not covered by my insurance benefits. I also authorize that photographic copy of this authorization is as if such copy were original. I also authorize the doctors to file a formal written complaint with the insurance commissioner if my insurance fails to pay or deny a claim within 30 days.

I have read, understood and agree to the provisions of this form.

Signature: _____ **Date:** _____

REASON FOR YOUR VISIT:

_____

_____

_____

ALLERGIES AND SENSITIVITIES

Check Yes or No if you have a history of skin reaction or other illness following contact with:

YES NO

- ☐ ☐ Prior Allergy Test
  If yes, results_____
- ☐ ☐ Penicillin, Sulfa or other antibiotic
- ☐ ☐ Morphine, Codeine, Demerol
- ☐ ☐ Novocain or Lidocaine
- ☐ ☐ Tetanus toxoid or serums
- ☐ ☐ Iodine, Betadine, Chlorhexidine or Phisohex
- ☐ ☐ Tincture of Benzoin
- ☐ ☐ Latex rubber or Adhesive tape

List other drug, medicine, or other allergies here:

DRUGS AND MEDICINES

Check Yes or No if you have taken any of the following within the last 6 months:

YES NO

- ☐ ☐ Cortisone, prednisone or ACTH
- ☐ ☐ Diuretics or water pills
- ☐ ☐ Blood pressure medication
- ☐ ☐ Steroids or body building drugs
- ☐ ☐ Seizure medication
- ☐ ☐ Insulin or diabetes medication
- ☐ ☐ Headache or migraine medications
- ☐ ☐ Asthma medication
- ☐ ☐ Heart medication
- ☐ ☐ Anticoagulants or blood thinners
- ☐ ☐ Pain pills
- ☐ ☐ Appetite suppressants or diet pills
- ☐ ☐ Sedatives, tranquilizers or sleeping pills
- ☐ ☐ Antidepressants, antipsychotics or nerve pills
- ☐ ☐ Recreational or illegal drugs
- ☐ ☐ Homeopathic or herbal medicines
- ☐ ☐ Aspirin or aspirin-containing medications

List ALL drugs or medications currently used:

SURGERY

Check Yes or No for each question:

YES NO

- ☐ ☐ Abnormal healing or poor scar formation
- ☐ ☐ Adverse or unusual reaction to surgery
- ☐ ☐ Abnormal bleeding

IMPORTANT MEDICAL CONDITIONS

Check Yes or No if you have been diagnosed or ever received treatment for any of the following:

YES NO

- ☐ ☐ Anaphalaxis or severe allergy attack
- ☐ ☐ Migraines, headaches or chronic head pain
- ☐ ☐ Seizures
- ☐ ☐ Glaucoma
- ☐ ☐ Stiff neck
- ☐ ☐ Artificial joint replacement
- ☐ ☐ Bell's palsy or neurological problems
- ☐ ☐ Asthma, TB, Pneumonia or chest disease
- ☐ ☐ High blood pressure
- ☐ ☐ Heart problems, palpitation, or surgery
- ☐ ☐ Pacemaker
- ☐ ☐ Splenectomy (removal of spleen)
- ☐ ☐ Blood clots or varicose veins
- ☐ ☐ Gastro esophageal reflux
- ☐ ☐ Hepatitis, jaundice, cirrhosis or liver disease
- ☐ ☐ HIV or AIDS
- ☐ ☐ Frequent nosebleeds or Easy bruising
- ☐ ☐ Cancer
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid problem or Graves' disease
- ☐ ☐ Kidney failure, kidney or prostate problems
- ☐ ☐ Lupus, arthritis or autoimmune disease
- ☐ ☐ X-Ray treatments or radiation therapy
- ☐ ☐ Severe snoring or sleep apnea

DENTURES

YES NO

- ☐ ☐ Capped teeth, bridges or veneers
- ☐ ☐ Loose teeth or gum disease
- ☐ ☐ Other oral/dental problems

ANESTHESIA

YES NO

- ☐ ☐ Adverse or unusual reaction to anesthesia
- ☐ ☐ Do you have a blood relative who had anesthesia complications of any kind

ADDITIONAL MEDICAL CONDITIONS

Check Yes or No if you have been diagnosed or ever received treatment for any of the following:

YES NO

- ☐ ☐ Drug or Alcohol abuse or addiction
- ☐ ☐ Smoking, currently or in the past
- ☐ ☐ Psychological or emotional problems
- ☐ ☐ Body Dismorphic Disorder (BDD)
- ☐ ☐ Currently in therapy or counseling
- ☐ ☐ Depressed or having Suicidal thoughts
- ☐ ☐ Is there violence in your home?
- ☐ ☐ Is anyone threatening you or making you feel bad about yourself?

EAR, NOSE & THROAT

Check Yes or No if you have been diagnosed or ever received treatment for any of the following or are having syptoms:

YES NO

- ☐ ☐ Eye Pain, Itchy or Water Eyes
- ☐ ☐ Double Vision, Sudden Vision changes
- ☐ ☐ Hearing Loss or Dizziness
- ☐ ☐ Ear Noises
- ☐ ☐ Ear Pain
- ☐ ☐ Nasal Congestion
- ☐ ☐ Shortness of Breath
- ☐ ☐ Problems with the Sense of Smell
- ☐ ☐ Snoring
- ☐ ☐ Sinus Pressure or Pain
- ☐ ☐ Post Nasal Drip
- ☐ ☐ Sneezing
- ☐ ☐ Hoarseness
- ☐ ☐ Difficulty Swallowing
- ☐ ☐ Coughing
- ☐ ☐ Daytime sleepiness
- ☐ ☐ Throat clearing
- ☐ ☐ Throat Pain
- ☐ ☐ Lip or Tongue Swelling

List other medical conditions here:

List all previous surgical procedures you have undergone & approximate date(s):

I certify that the above is true, correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to me or harm to those involved in my care. I am aware that providing false or incomplete information about my medical and surgical history may result in the cancellation of my proposed surgical procedure and also result in forfeiture of my surgical fees.

Patient Initials _____

Please Check All of Dr. Alessi's Surgical & Facial Institute's Non-Surgical Procedures That May Be of Interest To You:

FACE

- ☐ Facelift, Neck Lift, Brow Lift
- ☐ Eyelid Surgery
- ☐ Nose Surgery (cosmetic and
- ☐ Lip Surgery
- ☐ Facial Contouring, Implants, Fat
- ☐ Prominent Ear
- ☐ Other _____

BREAST

- ☐ Breast Augmentation
- ☐ Breast Revision/Reconstruction
- ☐ Breast Lifts
- ☐ Breast Reduction
- ☐ Scar Revisions
- ☐ Nipple Surgery
- ☐ Other _____

BODY

- ☐ Surgical Body
- ☐ Tummy Tucks
- ☐ Brazilian Butt Lift/Fat Transfer
- ☐ Body Lift, Arm Skin Reduction
- ☐ Scar Revisions (e.g., C-Sections)
- ☐ Labia Contouring/Reduction
- ☐ Other _____

NON INVASIVE PROCEDURES

- ☐ Botox or Dysport Injections
- ☐ Dermal Fillers (e.g.,Restylane, Juvederm)
- ☐ Lip Enhancements
- ☐ Non-Surgical Fat Reduction
- ☐ Hair Regeneration for thinning or receding hair
- ☐ Laser Treatments to Improve Skin Quality
- ☐ Laser Therapy to Improve Pigmentation or Spots
- ☐ Laser Therapy for Skin Tightening or Firming
- ☐ Medical Facials and Peels
- ☐ Anti-Aging, Prevention Skincare
- ☐ Alessi Skin Care
- ☐ PRP-Stem cell injections
- ☐ Hydrofacial
- ☐ Sun Damage Repair
- ☐ Acne Treatments
- ☐ Scar Treatment
- ☐ Eyelash Enhancement
- ☐ Not sure, need consultation
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

Check Yes or No if you have used in the past or are currently using:

YES	NO	
☐	☐	Retin-A or other Retinoids
☐	☐	Skin Lightening products
☐	☐	Accutane
☐	☐	Waxing or Depilatories
☐	☐	Laser treatments
☐	☐	IPL/Photofacial
☐	☐	Microdermabrasion
☐	☐	Facials
☐	☐	Injections (Botox/Dysport)
☐	☐	Dermal Fillers (Juvaderm)

Patient Initials _____

Patient & Photo Consent Form

Privacy and Confidentiality Notice

Privacy and Confidentiality Notice for David M. Alessi, M.D., A Medical Corporation

We understand that many patients are concerned about the privacy surrounding their decision to have surgery. Your decision to enhance your look is a personal one and it is our pledge that we will safeguard the information you provide to the best of our abilities. Please review this form carefully and sign below. If you have any questions, please do not hesitate to speak with our office manager, Surgical and/or our Plastic Surgery Coordinator.

Our efforts to safeguard your personal and medical information include training our staff on the principals and importance of patient confidentiality, keeping patient charts and photographs safe and secure, and transmitting only necessary information to facilities such as the surgery center, anesthesiologist, and in some cases the hospital.

A description of the information typically collected is listed here:

- To ensure the highest quality of medical care, you will be asked to share medical history information such as previous surgeries, allergies to medications and general health status.
- Additionally you will be asked to discuss with Dr. Alessi the reasons for your visit and your plastic surgery goals. Dr. Alessi often records this information in his chart notes.
- Pre and post procedure digital photographs are either sent ahead of your visit (by you) or taken in our office. These assist Dr. Alessi in planning surgery.
- For tracking and invoicing purposes, you will be asked to share personal information such as name, address, phone numbers, e-mail, social security number and credit card number(s). Again, we take the utmost care in handling this information.

Furthermore, I authorize my surgeon to use my **photographs, videotapes and case information in educational and scientific settings** (including lectures and multi-media presentations for an audience of medical professions, at which members of the press may be present, and medical, surgical and scientific journal articles).

Neither I, nor any member of my family will be identified by name in any publication. I understand that in some circumstances the photographs may portray features, which shall make my identity recognizable.

I authorize the use of my photographs, videotapes and case information in the following **commercial/educational settings**: my surgeon's office patient education materials; my surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office; newspaper and magazine articles in which my surgeon participates; television programs in which my surgeon participates; my surgeon's personal website or webpage; and, lectures and multi-media presentations given by my surgeon for the general public.

I release and discharge David M. Alessi M.D., F.A.C.S. and all parties acting under his license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above authorization and release and fully understand its terms.

I have read and understand the Privacy and Confidentiality Notice and all questions have been answered to my satisfaction. I understand I may have a copy of the Privacy and Confidentiality Notice if I wish.

Patient Signature	Print Name	Date
Witness/Physician Signature	Print Name	Date

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996(HIPAA).

Our Commitment to Your Privacy:
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and Disclosure of Your Health Information in Certain Special Circumstances:
The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. **Right to a copy of this note.** You are entitled to receive a copy of this Note of Privacy Practices. You may ask us to give you a copy of this notice anytime. To obtain a copy of this notice, contact our front desk receptionist.

6. **Right to file a complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact David M. Alessi, M.D., F.A.C.S. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. **Right to provide an authorization for other used and disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have question regarding this notice or our health information privacy policies, please contact the office of David M. Alessi, M.D. F.A.C.S.

I hereby acknowledge that I have been presented with a copy of David M. Alessi, M.D., F.A.C.S.

Notice of Privacy Practices

Signature:_____ **Date:**_____

Notice to Consumers
Medical doctors are licensed and regulated by the
Medical Board of California
(800) 633-2322
www.mbc.ca.gov

DAVID M ALESSI, M.D., F.A.C.S
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HILLS, CA 90210

Otolaryngology/Head and Neck Surgery
Facial Reconstructive & Plastic Surgery

Telephone: (310) 657-2253
Fax: (310) 657-2019

Patient Notification for Insurance payment Policies for certain In-Office Procedures

Patient Name: _____

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition of office visit charges. We have become aware that some Insurance carriers are classifying these procedures as "Surgery" and applying the charges to a higher deductible amount. The result may be insurance payment for an office visit but not a procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of patient care.

Examples of in-office procedures include:

Flexible laryngoscopy: This procedure involves passing a thin flexible fiberoptic scope through the nasal cavity and into the throat. The fiber optic scope enables the physician to visualize areas of the throat not readily seen using the laryngeal mirrors. Insurance allowed amount $ 133.26.

Fiberoptic Stroboscopy: Insurance allowed amount $ 251.17.

Nasal endoscopy: This procedure uses the flexible attached to light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror. Insurance allowed amount $ 217.81

Cerumen (ear wax) removal: When cerumen is impacted and requires the use of instruments and the microscope to remove, it is considered a separate procedure.

Microscope: The doctor sometimes needs to use the microscope to examine an area closely (for example the ears) in order to make a diagnosis. The use of the microscope is included in some procedures, but when it is used as part of the exam, it is sometimes a separate charge.

By signing this document, I agree/give my consent for Dr. Alessi to perform procedures required.

If you have any questions, please do not hesitate to ask.

_____ _____

Patient Signature **Date**