The Maloney Center for Facial Plastic Surgery
6111 Peachtree Dunwoody Rd., Bldg E Suite 201, Atlanta, GA 30328
Phone: 770-804-0007 Fax: 770-804-0777

DATE____________________________

FULL NAME ____ SEX ________ AGE _______

BIRTHDATE ____________ SOCIAL SECURITY # _________________________

ADDRESS____ CITY____________________________

STATE _____ ZIPCODE ________ EMAIL ADDRESS ____

Marital Status __________ Home Phone #_____________________ Mobile/Cell # _________________________

Employer ___________________________ Occupation ______________________ Work # _________________

Address_______________________________________City___________________State_____ZipCode_________

Spouse's Name __________________Spouse's Employer _____________________Occupation________________

Closest local relative or friend not living with you____

Address ____Phone #__________________________

Children's names and ages____

Any family member treated here before? ______ If yes, name/relationship / approximate date _________________

If the PATIENT is a MINOR, please complete this section:

Father's Name ________________________________Employer ____________________ Phone#_____________

Mother's Name ________________________________ Employer ____________________Phone# _____________

Person Responsible For Bill, (if other than patient)

Name _______________________________Relationship to Patient ____________ Phone#___________________

Address_______________________________________ City________________ State_____ Zip Code__________

REFERRAL SOURCE

Physician (Specify) ____
Friend (Specify) ____
TV/ Network ____________________________
Website (Specify) Google____ Maloney Center ____ RealSelf ____Other____________________________
Skin Care (Specify) ____
Magazine (Specify) ____
Seminar ____
Other____

OUT OF STATE AND INTERNATIONAL PATIENTS,
PLEASE LET US KNOW IF WE CAN ASSIST WITH YOUR TRAVEL PLANS

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PERSONAL HISTORY

NAME: ________________________________

Please list any medical problems or previous hospitalizations______________________________
____

Have you had any serious past illnesses?____

Please list any accidents or injuries____

Please list any past surgeries (including minor surgery or surgery as a child)_________________
____

YES NO

___ ___ Do you have any allergies to medication? List medications _____________________
____
___ ___ Do you have any food, environmental, or latex allergies? List reactions___________
____
___ ___ Are you currently taking any drug or medications? How often? List (Include over the counter)____
____ ___ Do you take vitamins or herbal products? List________________________________
____ ___ Do you drink more than 6 cups of coffee per day?
____ ___ Do you drink alcohol? How much? How often?_______________________________
____ ___ Do you smoke? How much per day?____
____ ___ Do you ever get cold sores or fever blisters?_________________________________
____ ___ Do you have skin sensitivities, frequent rashes, or eczema?
____ ___ Have you ever taken Accutane?
____ ___ Do you have a skincare regimen you follow? Describe_________________________
____
____ ___ Have you ever received local anesthesia? (Novacaine)
____ ___ Did you have a reaction to anesthesia?
____ ___ Are you a past/present carrier of a contagious disease? Please specify____________
____
____ ___ Are you or could you be pregnant?
____ ___ Have you taken medicine such as Cortisone or steroid during the past year?
____ ___ Do you have a personal or family history of any bleeding or clotting abnormalities?
____ ___ Do you bleed for more than a half hour after a needle stick?
____ ___ Do you bleed a day or more after surgery or a tooth extraction?
____ ___ Do you bruise easily?
____ ___ Do you bruise without cause?
____ ___ Do you bruise larger than a half dollar?
____ ___ Do you bruise from injections?

DATE OF YOUR LAST PHYSICAL?_____________DATE OF MOST RECENT BLOODWORK_____________DATE OF YOUR LAST CHEST X-RAY______________________HAVE YOU HAD AN ABNORMAL CHEST X-RAY?_______DATE OF LAST EKG__________________HAVE YOU HAD AN ABNORMAL EKG_______

PRIMARY CARE PHYSICIAN____PHONE#______________________

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NAME:____

DO YOU HAVE OR HAVE YOU EVER HAD:

YES	NO	
_____	_____	Heart disease or heart trouble
_____	_____	High blood pressure
_____	_____	Lung disease
_____	_____	Hay fever
_____	_____	Kidney disease
_____	_____	Liver disease
_____	_____	Epilepsy/seizures/neurological problems
_____	_____	Thyroid or goiter problems
_____	_____	Chest pain
_____	_____	Chronic cough
_____	_____	Recent respiratory infection
_____	_____	Skin trouble/infections/rashes/irritations
_____	_____	Keloid or ugly scars
_____	_____	Glaucoma
_____	_____	Phlebitis
_____	_____	Problems lying flat
_____	_____	Nosebleeds
_____	_____	Fainting
_____	_____	Asthma
_____	_____	Have you considered seeing a psychologist/ therapist
_____	_____	Are you seeing a therapist now?
_____	_____	Are you on a special diet?
_____	_____	Recent weight loss (amount)_________
_____	_____	Any exposure to a communicable disease in the last 3 weeks? Explain_______________

YES	NO	
____	____	Mitral valve prolapse
____	____	Diabetes
____	____	Muscle weakness
____	____	Difficulty urinating
____	____	Jaundice
____	____	Headache or dizzy spells
____	____	Bowel/colon disease or problems
_____	____	Shortness of breath
_____	____	Back or neck trouble
_____	____	Ulcers/stomach trouble
_____	____	Do you use eye drops?
_____	____	Treatment of genital area
_____	____	Are you easily depressed
_____	____	Hiatal hernia
_____	____	Blood transfusion
_____	_____	Ankle swelling
_____	_____	Facial fractures
_____	_____	Anemia
_____	_____	Drug or alcohol dependency

____________Height

____________Weight

____

DO YOU HAVE ANY OF THE FOLLOWING: Dentures______Partial plate_____Bridgework_______

ARE YOU WEARING ANY OF THE FOLLOWING: Contacts___False eyelashes___Hearing aid____
Wig/hairpece_____ Permanent eyeliner or other
Permanent cosmetics ____________________

FAMILY HISTORY: Diabetes____Bleeding____Heart disease____Anesthesia problems_____________
Other____

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR HEALTH?____

Signed____
(Patient or Guardian)

THE REQUESTED PERSONAL INFORMATION IS A NECESSARY PART OF OUR EVALUATION. ALL INFORMATION GIVEN TO US IS CONFIDENTIAL.

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AUTHORIZATION FOR EXAMINATION

Name:____

Date of Birth:____

I, _______________________________________, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery/ treatment. I authorize the taking of photographs at the direction of my physician and under such conditions as may be approved by him.

SIGNATURE:____DATE:_______________________

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN

WITNESS:____

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NON-INSURANCE ACKNOWLEDGEMENT

Name:____

Date of Birth:____

I understand and accept that The Maloney Center for Facial Plastic Surgery reserves the right to not participate in any insurance filings, related to any procedures and/ or surgeries performed by Dr. Brian Maloney. A copy of this acknowledgement shall be considered as valid as the original.

I understand I am responsible for professional services rendered as outlined in the financial policy.

SIGNATURE:____DATE:_______________________

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN

WITNESS:____DATE:_______________________

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CONSENT TO RECEIVE TEXTS AND/OR EMAILS

Name:____

Date of Birth:____

To provide you with the safest and most up to date services we have created a document that protects you, the patient. With the increased use of text messaging for appointment reminders we want to make sure you are aware that you will be texted appointment reminders. You have the option at any time to OPT out of this service.

“Federal law prohibits this practice from sending you texts or email which are unencrypted or “unsecure”.” However, many of our patients find it convenient to communicate with our office by traditional text and/or email. Those modes of communication are generally not considered “secure”. Some of our patients appreciate the tradeoff between ease of use/ convenience and security. We want to accommodate your preferences. If you would like to communicate with us by “unsecure” text or email, please confirm below by providing your authorization. We will keep your preferences in force with no current expiration date until we learn otherwise. You can change your mind at any point down the road. With our texting service you have the option at any time to OPT out of receiving text messages. If messages are sent through such channels, they may no longer be protected by HIPAA. Finally, whether or not you decide to use email or text messaging, your choice will have no impact on our decision to treat you.

I authorize the practice to communicate with me by “unsecure” text; that text number being:

____ number

____ signature/date

I authorize the practice to communicate with me by “unsecure” email, that email address being:

____ email address

____ signature/ date