CHRISTINE HAMORI
COSMETIC SURGERY + SKIN SPA

No Changes _____ _____ _____ _____ _____ _____

For Office Use Only: Physician Initials_____ Nurse Initials_____ Entered by_____

Patient Information

Today's Date _____

Patient Full Name _____ Nickname used _____

Home Address _____ City _____ State _____ Zip _____

Social Security Number_____ Date of Birth_____ Age_____

Check: ☐ Married ☐ Single ☐ Widow(er) ☐ Divorced ☐ Separated Maiden Name _____

Home Phone (_____)_____ e-mail address _____

Work Phone (_____)_____ extension _____ Cell Phone (_____)_____

Please circle where you would like your appointments confirmed: **Check only if you do not want us to call and/or leave messages:**

HOME CELL WORK EMAIL ☐ home ☐ work ☐ cell ☐ e-mail

Employer Name _____ Occupation _____

Address _____ City _____ State_____ Zip _____

Primary Care Doctor _____ Practice Name_____

Address _____ City _____ State _____ Zip_____

Phone (_____)_____ Fax (_____)_____

How did you hear of us? Please circle one or more of the following:

Internet/Websites – Love Your Look Looking Your Best Plastic Surgery.com Breast Implants 411 Botox Cosmetics.com

Magazines – New Beauty Boston Magazine South Shore Living Cape Cod Magazine South Shore Magazine

Radio/TV – COOL 102 THE ROSE 96.3 WCOD 106 **Newspapers** – Duxbury Clipper Cape Cod Times Boston Globe

Yellow Pages Patient Doctor Word of Mouth

Other _____

Has this office previously treated any member of your family? ☐Yes ☐No If Yes, whom _____

EMERGENCY CONTACT:

Name _____ Relationship _____ Occupation _____

Home Phone (_____) _____ Work Phone (_____) _____ Ext _____

WHAT BRINGS YOU HERE *(check all that apply)*

- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Belt Lipectomy
- ☐ Blepharoplasty (eyelid surgery)
- ☐ Breast Augmentation
- ☐ Breast Lift
- ☐ Breast Reconstruction
- ☐ Breast Reduction
- ☐ Face Lift
- ☐ Gynecomastia
- ☐ Labioplasty
- ☐ Liposuction / Liposculpture
- ☐ Neck Lift
- ☐ Nipple Surgery
- ☐ Rhinoplasty
- ☐ Scar Evaluation
- ☐ Thermage body\face
- ☐ Botox
- ☐ Sculptra
- ☐ Restylane/Juvederm/Prevelle
- ☐ Radiesse/Perlane
- ☐ Skin Consult
- ☐ Acne Treatment
- ☐ Varilite Laser
- ☐ Facial lines /Crows feet
- ☐ Facial Spider Veins
- ☐ Laser Hair Removal
- ☐ Leg Spider Veins
- ☐ Microdermabrasion
- ☐ IPL (intense pulse light)
- ☐ Cellulite treatment

Other please list_____

PAST MEDICAL HISTORY:

	HAVE		RECEIVE TREATMENT		LIMITS YOUR ACTIVITIES	
	YES	NO	YES	NO	YES	NO
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Ulcer or Stomach Disease	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Anemia or blood disease	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Osteoarthritis, degenerative arthritis	☐	☐	☐	☐	☐	☐
Back pain	☐	☐	☐	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐	☐	☐	☐
Other medical problems(please specify)	☐	☐	☐	☐	☐	☐
Any hospitalizations in last year	☐	☐	☐	☐	☐	☐
Any problem with general anesthesia	☐	☐	☐	☐	☐	☐

PREVIOUS SURGERIES AND INJURIES *(Please List)*

Operation	Year / Doctor	Complications, if any

MEDICATIONS, DRUGS (*Please check all medications you are now taking*)

- ☐ Birth Control Pills
- ☐ Diuretics (water pills)
- ☐ Blood pressure
- ☐ Heart Medication
- ☐ Tranquilizers
- ☐ Hormones
- ☐ Steroid Medications
- ☐ Cortisone
- ☐ Blood Thinners (aspirin, bufferin, advil etc.)
- ☐ Vitamins
- ☐ Supplements
- ☐ Herbal products
- ☐ Recreational drugs
- ☐ Tamoxifen

PLEASE NAME MEDICATIONS	DOSE	FREQUENCY

FAMILY HISTORY

☐ Breast Cancer ☐ Skin Cancer ☐ Heart Disease ☐ Vascular Disease ☐ Other Cancer(s) _____

MATERNAL HISTORY

Have you ever been pregnant? ☐ Yes ☐ No If yes, how many times ___ How many children do you have? _____

Are you pregnant? ☐ Yes ☐ No Are you planning more children? ☐ Yes ☐ No ☐ Don't know

DATE OF LAST MAMMOGRAM _____ Where_____ Results: ☐ Normal ☐ Abnormal

ALLERGIES TO MEDICATION ☐ Yes ☐ No

☐ **LATEX** ☐ **PENICILLIN** ☐ **SULFA** ☐ **CODEINE**

OTHERS *(Please List)* _____

Weight_____ **Height**_____ **Pant size**_____ **Dress Size**_____ **Bra Size**_____

GENERAL HISTORY	YES	NO	Comments
Do you have nausea from general anesthesia?	☐	☐	_____
Have you ever had a bad reaction to general anesthesia?	☐	☐	_____
At the dentist, do you have difficulty with local anesthesia?	☐	☐	_____
Do you bleed easily from cuts or surgery?	☐	☐	If yes what happened? _____
Do you form large scars or keloids?	☐	☐	_____
Do you have frequent infections or boils?	☐	☐	_____
Do you have recurring cold sores, Herpes or Zoster?	☐	☐	Where/how often? _____
Have you ever had any significant emotional problems?	☐	☐	If yes what? _____
Have you ever had psychiatric care?	☐	☐	_____
Have you ever been advised to see a psychiatrist ?	☐	☐	_____
Have you ever seen other plastic surgeons about the **SAME** problem that brings you here ?	☐	☐	_____
Do you drink alcohol?	☐	☐	If so, how much? _____
Are you a smoker?	☐	☐	If so, how much? _____

AUTHORIZATION FOR TREATMENT:

I hereby consent to my examination and treatment in the office of Dr. Christine A. Hamori. In addition, I authorize the doctor to obtain records of my medical treatment from other hospitals or physicians.

- I understand that treatment for my medical condition is strictly between the doctor and myself.

SIGNATURE_____DATE_____

RELATIONSHIP TO PATIENT (SELF, PARENT/GUARDIAN, ETC)_____

Christine Hamori Cosmetic Surgery & Skin Spa
Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Christine Hamori Cosmetic Surgery & Skin Spa for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Christine Hamori Cosmetic Surgery & Skin Spa. I understand that diagnosis or treatment of me by Dr. Hamori may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Christine Hamori Cosmetic Surgery & Skin Spa is not required to agree to the restrictions that I may request. However, if Christine Hamori Cosmetic Surgery & Skin Spa agrees to a restriction that I request, the restriction is binding on Christine Hamori Cosmetic Surgery & Skin Spa and Dr. Hamori.

I have the right to revoke this consent, in writing, at any time, except to the extent that Christine Hamori Cosmetic Surgery & Skin Spa has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Christine Hamori Cosmetic Surgery & Skin Spa's Notice of Privacy Practices prior to signing this document. The Christine Hamori Cosmetic Surgery & Skin Spa's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Christine Hamori Cosmetic Surgery & Skin Spa. The Notice of Privacy Practices for Christine Hamori Cosmetic Surgery & Skin Spa is also provided at 95 Tremont Street, Suite 28, Duxbury, MA and on the Christine Hamori Cosmetic Surgery & Skin Spa's website at **www.christinehamori.com.** This Notice of Privacy Practices also describes my rights and the Christine Hamori Cosmetic Surgery & Skin Spa's duties with respect to my protected health information.

Christine Hamori Cosmetic Surgery & Skin Spa reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Christine Hamori Cosmetic Surgery & Skin Spa's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative	Date
Print Name of Patient or Personal Representative	Description of Personal Representative's Authority

CHRISTINE HAMORI
COSMETIC SURGERY + SKIN SPA

Christine A. Hamori, MD
Board Certified Plastic Surgeon
95 Tremont Street, Suite 28
Duxbury, MA 02332

781.934.2200
781.934.7301 fax
cah@christinehamori.com
www.christinehamori.com

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

Informed Consent – Photographs

Authorization for and release of medical photographs/slides and/or videotapes

Instructions

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

Introduction

Medical photographs/slides and videotapes may be taken before, during, or after surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photography/slides and videotapes for a stated purpose.

1. Consent to take photographs/slides/videotapes

I hereby authorize Christine Hamori, M.D. and his/her associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes. I additionally consent to photographs, slides, and/or videotapes of my consultation. These are strictly for my chart and/or for Dr. Hamori's use during an elective procedure or surgery only.

Patient Signature: _____ Date _____

Witness: _____

2. Consent for release of photographs/slides/videotapes

I hereby authorize Christine Hamori, M.D. and his/her associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate, including but not limited to showing these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Patient Signature: _____ Date _____

Witness: _____