Gemini Plastic Surgery
Aesthetics & Laser Center
Della C. Bennett, M.D. F.A.C.S.

PATIENT CONTACT INFORMATION

Home Phone Number: _____

Work Phone Number: _____

Cell Phone Number: _____

Email Address: _____

Mailing Address: _____

_____

_____

WHAT ARE YOU INTERESTED IN?:

BREAST
- ☐ Augmentation
- ☐ Reduction
- ☐ Lift

BODY CONTOURING
- ☐ Tummy Tuck
- ☐ Liposuction
- ☐ Arm Reduction
- ☐ Buttock Lift

FACIAL REJUVENATION
- ☐ Browlift
- ☐ Eyelid Surgery
- ☐ Facelift
- ☐ Necklift
- ☐ Chin

NON-SURGICAL
- ☐ Laser
- ☐ Botox
- ☐ Fillers
- ☐ Body Contouring

AESTHETICIAN SERVICES
- ☐ Skin Care
- ☐ Peels
- ☐ Facials

NUTRITION
- ☐ Weight Reduction
- ☐ Anti-Aging

HOW DID YOU HEAR ABOUT GEMINI PLASTIC SURGERY?

- ☐ Patient
- ☐ Print Ad
- ☐ Internet
- ☐ Friend
- ☐ Physician
- ☐ Seminar
- ☐ American Society of Plastic Surgery
- ☐ Other:_____

NOTICE OF PRIVACY POLICY

Gemini Plastic Surgery **Aesthetics & Laser Center** ☐ Della C. Bennett, M.D. F.A.C.S.	Patient Name: DOB: MR#: Date:

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The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities the misuse personal health information.
As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.**
- **Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.**
- **Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.**

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- **The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.**
- **The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.**
- **The right to inspect and copy your protected health information.**
- **The right to amend your protected health information.**
- **The right to receive an accounting of disclosures of protected health information.**
- **The right to obtain a paper copy of this notice from us upon request**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have reviewed the Notice of Privacy Practices stated above. I understand that this organization has the right to change its Notice of Privacy Practices, and that I may contact the organization at any time to obtain a copy of the Notice of Privacy Practices.

PATIENT NAME:_____

_____ _____
PATIENT SIGNATURE **DATE**

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REFUND POLICY

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed and are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Dr. Bennett to use and disclose my protected health information to any credit card entity, bank, or financing company when they request such information to process an account and assist with payment.

I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

I agree that this non credit card challenge agreement is irrevocable.
You can cancel and re-schedule at any time by calling (909)463-0715

Office credit will be given on unused treatments in a package. There will be no refunds in any form of payment.
Thank you for your anticipated cooperation.

NO SHOW POLICY

$50.00 Charge For No-Shows You will be considered a NO-SHOW if you miss an appointment and do not notify us in advance. (24 HOURS IN ADVANCE)
Payment of the NO-SHOW fee must be made in cash or valid credit card before any further appointments are allowed.
Please update your home and cellular telephone numbers, and your e-mail address each time you visit, or at any time over the phone.

AGREED & ACCEPTED

Patient Name:_____

Patient Signature:_____ Date:_____

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PAST MEDICAL HISTORY & REVIEW OF SYMPTOMS

PERSONAL INFORMATION

Date of Birth:	
Birthplace:	
Marital Status:	
Education:	
Occupation(s):	
Recreation:	
Exercise:	
Y or N Alcohol Daily Amount & Type:	
Y or N Tobacco Amount & Type:	
Y or N Tea/Coffee Amount & Type:	

MEDICATIONS TAKEN REGULARLY	REASON	DOSE/FREQUENCY

ALLERGIES	
TETANUS ANTITOXIN	Y OR N
PENICILLIN	Y OR N
SULFA	Y OR N
LATEX	Y OR N
OTHER:	

IMMUNIZATIONS	
SMALL POX	Y OR N
TETANUS	Y OR N
POLIO SHOT	Y OR N
POLIO ORAL	Y OR N
HEPATITIS	Y OR N

PERSONAL PAST HISTORY

MENINGITIS	Y OR N	YEAR:
INFECTIOUS MONO	Y OR N	YEAR:
TUBERCULOSIS	Y OR N	YEAR:
EXPOSURE TO TB	Y OR N	YEAR:
ARTHRITIS	Y OR N	YEAR:
BACK/NECK PAIN	Y OR N	YEAR:
BRONCHITIS	Y OR N	YEAR:
PNEMONIA	Y OR N	YEAR:
HAY FEVER/SINUSITIS	Y OR N	YEAR:
ASTHMA	Y OR N	YEAR:
EMPHYSEMA	Y OR N	YEAR:
RHEUMATIC FEVER	Y OR N	YEAR:
HIGH BLOOD PRESSURE	Y OR N	YEAR:
HEART DISEASE	Y OR N	YEAR:
BLOOD CLOTS/DVT	Y OR N	YEAR:
PULMONARY EMBOLISM	Y OR N	YEAR:
ANEMIA	Y OR N	YEAR:
BLEEDING/TRANSFUSION	Y OR N	YEAR:
HEPATITIS	Y OR N	YEAR:
BLADDER INFECTIONS	Y OR N	YEAR:
GLAUCOMA	Y OR N	YEAR:

PERSONAL OPERATIVE HISTORY

ANESTHESIA		
MALIGNANT HYPOTHERMIA	Y OR N	YEAR:
TRACH TUBE COMPLICATION	Y OR N	YEAR:
OTHER:		
OPERATIONS		
FACIAL	Y OR N	YEAR:
APPENDIX	Y OR N	YEAR:
GALLBLADDER	Y OR N	YEAR:
STOMACH	Y OR N	YEAR:
BREAST	Y OR N	YEAR:
UTERUS	Y OR N	YEAR:
PROSTATE	Y OR N	YEAR:
HERNIA	Y OR N	YEAR:
THYROID	Y OR N	YEAR:
VARICOSE VEINS	Y OR N	YEAR:
HEMORRHOIDS	Y OR N	YEAR:
HEART	Y OR N	YEAR:
LIPOSUCTION	Y OR N	YEAR:
OTHER:		
INJURIES		
HEAD/NECK	Y OR N	YEAR:
CHEST	Y OR N	YEAR:
ABDOMEN	Y OR N	YEAR:
BROKEN BONES	Y OR N	YEAR:
BACK	Y OR N	YEAR:
OTHER:		

FAMILY HISTORY

LIST BLOOD RELATIVES THAT HAVE HAD ANY OF THE FOLLOWING:

ANEMIA/BLEEDING DISORDER	Y OR N	RELATION:
LEUKEMIA	Y OR N	RELATION:
BLOOD CLOTS/DVT	Y OR N	RELATION:
PULMONARY EMBOLISM	Y OR N	RELATION:
REPEATED INFECTIONS	Y OR N	RELATION:
CRIPPLING INFECTIONS	Y OR N	RELATION:
HEART DISEASE	Y OR N	RELATION:
CHRONIC LUNG DISEASE	Y OR N	RELATION:
ASTHMA	Y OR N	RELATION:
SEVERE ALLERGIES	Y OR N	RELATION:
MENTAL ILLNESS	Y OR N	RELATION:
CONVULSIONS OR FITS	Y OR N	RELATION:
MIGRANINE HEADACHES	Y OR N	RELATION:
DIABETES	Y OR N	RELATION:
OBESITY	Y OR N	RELATION:
THYROID DISEASE	Y OR N	RELATION:
PEPTIC ULCER	Y OR N	RELATION:
CANCER	Y OR N	RELATION:
MALIGNANT HYPERTHERMIA	Y OR N	RELATION:

	PRESENT AGE OR AGE AT DEATH				HEALTH (GOOD, FAIR, POOR) OR CAUSE OF DEATH			
FATHER								
MOTHER								
SIBLINGS								
CHILDREN								

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PAST MEDICAL HISTORY & REVIEW OF SYMPTOMS

GENERAL	
TIRES EASILY, WEAKNESS	Y OR N
MARKED WEIGHT CHANGE	Y OR N
NIGHT SWEATS	Y OR N
PERSISTENT FEVER	Y OR N
SENSITIVITY TO HEAT	Y OR N
SENSITIVITY TO COLD	Y OR N
SKIN	
ERUPTIONS (RASH)	Y OR N
CHANGE IN COLOR	Y OR N
CHANGE IN HAIR	Y OR N
CHANGE IN NAILS	Y OR N
EYES	
TROUBLE SEEING	Y OR N
EYE PAIN	Y OR N
INFLAMMED EYES	Y OR N
DOUBLE VISION	Y OR N
WORN GLASSES/CONTACTS	Y OR N
EARS	
LOSS OF HEARING	Y OR N
RINGING IN EARS	Y OR N
DISCHARGE	Y OR N
NOSE	
LOSS OF SMELL	Y OR N
FREQUENT COLDS	Y OR N
OBSTRUCTION	Y OR N
EXCESS DISCHARGE	Y OR N
NOSEBLEEDS	Y OR N
MOUTH	
SORE GUMS	Y OR N
SORNESS OF TONGUE	Y OR N
DENTAL PROBLEMS	Y OR N
THROAT	
POSTNASAL DRAINAGE	Y OR N
SORENESS	Y OR N
HOARSENESS	Y OR N
BREASTS	
LUMPS	Y OR N
DISCHARGE	Y OR N
CARDIO-RESPIRATORY	
PERSISTENT COUGH	Y OR N
SPUTUM	Y OR N
BLOODY SPUTUM	Y OR N
WHEEZING	Y OR N
CHEST PAIN OR DISCOMFORT	Y OR N
PAIN ON BREATHING	Y OR N
SHORTNESS OF BREATH	Y OR N
DIFFICULTY BREATHING	Y OR N
SWELLING OF ANKLES	Y OR N
BLUISH FINGERTIPS OR LIPS	Y OR N
HIGH BLOOD PRESSURE	Y OR N
PALPITATIONS	Y OR N
VEIN TROUBLE	Y OR N

DIGESTIVE	
CHANGE IN APPETITE	Y OR N
DIFFICULTY SWALLOWING	Y OR N
HEARTBURN	Y OR N
ABDOMINAL DISTRESS	Y OR N
BLEEDING OR EXCESS GAS	Y OR N
ABDOMINAL ENLARGEMENT	Y OR N
NAUSEA	Y OR N
VOMITING	Y OR N
RECTAL BLEEDING	Y OR N
TARRY STOOLS	Y OR N
DARK URINE	Y OR N
JAUNDICE	Y OR N
CONSTIPATION	Y OR N
DIARRHEA	Y OR N
HEMORRHOIDS	Y OR N
GENITOURINARY	
INCREASED FREQUENCY OF URINATION (DAY)	Y OR N
INCREASED FREQUENCY OF URINATION (NIGHTS)	Y OR N
FEEL NEED TO URINATE WITHOUT MUCH URINE	Y OR N
UNABLE TO HOLD URINE	Y OR N
ALBUMINURIA	Y OR N
IMPOTENCE	Y OR N
LACK OF SEX DRIVE	Y OR N
PAIN WITH INTERCOURSE	Y OR N
ENDOCRINE	
THYROID TROUBLE	Y OR N
ADRENAL TROUBLE	Y OR N
CORTISONE TREATMENT	Y OR N
DIABETES	Y OR N
LOCOMOTOR	
MUSCLE CRAMPS	Y OR N
MUSCLE WEAKNESS	Y OR N
PAIN IN JOINTS	Y OR N
SWOLLEN JOINTS	Y OR N
DEFORMITY OF JOINTS	Y OR N
STIFFNESS	Y OR N
NERVOUS SYSTEM	
HEADACHES	Y OR N
DIZZINESS/FAINTING	Y OR N
CONVULSIONS OR FITS	Y OR N
NERVOUSNESS	Y OR N
DEPRESSION	Y OR N
CHANGE IN SENSATION	Y OR N
MEMORY LOSS	Y OR N
POOR COORDINATION	Y OR N
WEAKNESS OR PARALYSIS	Y OR N
SLEEPING DISORDER	
SNORING	Y OR N
EXCESSIVE SLEEPINESS	Y OR N
PAUSES IN BREATHING WHILE SLEEPING	Y OR N
INSOMNIA	Y OR N
SLEEPLESSNESS	Y OR N

What it the major reason for today's visit?_____

_____ _____ _____ _____

PATIENT SIGNATURE **DATE** **PHYSICIAN SIGNATURE** **DATE**

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