TODAY'S DATE: _____

NAME: _____ PRONOUNS: _____ AGE: _____

ADDRESS: _____ DATE OF BIRTH: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SSN: _____ SEX: **M** **F** **OTHER** (please circle)

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMAIL ADDRESS: _____

EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE: _____ RELATIONSHIP: _____

WOULD YOU LIKE TO RECEIVE INFORMATION ON ACTIVITIES AND EVENTS THROUGH EMAIL? **YES** **NO**

PRIMARY INSURANCE: _____ EMPLOYER: _____

SUBSCRIBER: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER DOB: _____ SUBSCRIBER SSN: _____

POLICY # _____ GROUP: _____

SECONDARY INSURANCE: _____ EMPLOYER: _____

SUBSCRIBER: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER DOB: _____ SUBSCRIBER SSN: _____

POLICY # _____ GROUP: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ FRIEND/FAMILY MEMBER: _____

☐ PHYSICIAN: _____

☐ PATIENT: _____

☐ SOCIAL MEDIA: _____

☐ OTHER: _____

☐ BETHESDA MAGAZINE

☐ NORTHERN VIRGINIA MAGAZINE

☐ WASHINGTONIAN MAGAZINE

☐ INTERNET SEARCH/GOOGLE

☐ BRUNO|BROWN WEBSITE

REASON FOR VISIT: _____

HEIGHT: _____ WEIGHT: _____

CURRENT MEDICATIONS: _____ ALLERGIES: _____

& SUPPLEMENTS _____ _____

_____ _____

_____ _____

PRIMARY PHYSICIAN'S NAME AND NUMBER: _____

ARE YOU PREGNANT? **YES** **NO** **N/A** ARE YOU NURSING? **YES** **NO** **N/A**

DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE)

☐ HEART DISEASE	☐ LIVER PROBLEMS	☐ ASTHMA	☐ HEPATITIS
☐ HIGH BLOOD PRESSURE	☐ DRY EYE SYNDROME	☐ GLAUCOMA	☐ STROKE
☐ SHORTNESS OF BREATH	☐ HEPATITIS	☐ CHEST PAIN	☐ ARTHRITIS
☐ CANCER	☐ DIABETES	☐ BRONCHITIS	☐ SEIZURES
☐ ANEMIA	☐ COLD SORES	☐ DEPRESSION/ANXIETY	☐ ULCERS
☐ EASY BRUISING	☐ THYROID PROBLEMS	☐ AIDS/HIV	☐ SLEEP APNEA
☐ KIDNEY DISEASE	☐ NERVOUS CONDITION	☐ BLEEDING DISORDER	☐ BLOOD CLOTS/DVT

PLEASE LIST ANY ADDITIONAL MEDICAL PROBLEMS THAT HAVE NOT BEEN ADDRESSED: _____

_____

PAST SURGICAL PROCEDURES WITH DATES: _____

_____

DO YOU SMOKE? **YES** **NO** DO YOU DRINK ALCOHOL? **YES** **NO** IF YES, PLEASE PROVIDE AMOUNT AND FREQUENCY:

_____

HAVE YOU EVER HAD A PROBLEM WITH DRUGS OR ALCOHOL NOW OR IN THE PAST? **YES** **NO**

PREFERRED PHARMACY INFORMATION

PHARMACY NAME AND PHONE NUMBER: _____

PHARMACY ADDRESS: _____

OTHER INTERESTS:

___LIPOSUCTION	___BOTOX	___SKIN REJUVENATION
___BREAST LIFT	___NECK LIFT	___LASER RESURFACING
___BREAST REDUCTION	___EYELID SURGERY	___ARM LIFT
___BREAST AUGMENTATION	___RHINOPLASTY (NOSE JOB)	___OTOPLASTY (EAR PINNING)
___TUMMY TUCK	___FACELIFT	___DOUBLE CHIN (KYBELLA)
___BRAZILIAN BUTT LIFT	___BROWLIFT	___INTENSE PULSED LIGHT THERAPY (IPL)
___THIGH LIFT	___FACIAL/LIP FILLER	___SPOT TREATMENT/SCAR MANAGEMENT
___BREAST REDUCTION	___FACIAL/CHEMICAL PEEL	___PLATELET RICH PLASMA TREATMENT (PRP)

Patient's Authorization to Release Medical Information / Claim Payment Authorization
For Medical Insurance Purposes

I hereby authorize Dr. Bruno/Brown to release any information regarding services rendered by him and allow a photocopy of my signature to be used to file insurance.

_____ X_____

DATE PATIENT

I agree to present all claims to my health insurance carrier. I understand that I will remain liable for all physician's charges, and in the event of PAST DUE accounts, I understand that collection costs, court costs, and reasonable attorney's fees will apply to all past due accounts. I hereby authorize and direct payment check(s) for benefits due me for the services rendered by Dr. Bruno/Brown to be made directly to him.

_____ X_____

DATE PATIENT

CONSENT TO TAKE PHOTOGRAPHS FOR YOUR MEDICAL RECORD

The use of before and after photographs is essential to the planning and evaluation of plastic surgery and are part of your permanent medical record.

- They provide an accurate record of your appearance before surgery
- Should you or your physician decide on further consultations, photographs add scope and clarity to your discussions
- They assist your physician in planning your operation. Accurate medical photographs act as an "instrument" the doctor can work with using overlays, drawings and written indications for guidance.
- In the operating room, your photographs become an integral part of the surgical procedure, serving as an immediate and reliable reference during every step.
- Medical photographs are a reliable visual document to which you and your surgeon can refer at any time.

_____ X_____

DATE PATIENT

CONSENT TO RELEASE PHOTOGRAPHS

I hereby authorize Bruno|Brown Plastic Surgery to take and use pre-operative, intra-operative, and post-operative photographs for professional medical purposes deemed appropriate. This may include, but is not limited to, showing these images for purposes of medical and patient education.

Your **anonymous** photographs are also essential for use in patient education in the office, at seminars, at medical conferences, and on our website for the purpose of educating prospective patients who are in the process of choosing a plastic surgeon or evaluating specific procedures. **All pictures will remain completely anonymous and every effort is made to remove any identifiable features such as tattoos, birthmarks, or jewelry**.

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

_____ X_____

DATE PATIENT

Acknowledgment of Receipt of Notice to Patients – Form 1

I acknowledge that I was provided with a copy of the General Notice of my rights regarding my medical records.

_____
Name of Patient (printed) Date

_____
Signature of Patient (or Guardian)

Release of Medical records – Form 2

I acknowledge that I was provided with a copy of the General Authorization for Release of Medical Records, and that these policies may be changed by the provider and I will be given an update if this occurs.

_____ _____
Name of Patient (printed) Date

_____ _____
Signature of Patient (or Guardian) Date

DISCLOSURE TO FAMILY/FRIENDS

_____ I **do not** want Bruno|Brown Plastic Surgery ("Provider") to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

_____ I authorize Provider to disclose information related to my care and treatment to the following named individual(s):
_____ _____

The authorizations provided for above are subject to the following limitations or restrictions:

_____

_____ _____
Name of Patient (Printed) Signature of Patient (or Guardian) Date

THANK YOU FOR VISITING BRUNO | BROWN PLASTIC SURGERY.