

**LUCIAN J. RIVELA, M.D., F.A.C.S.**  
**PATIENT INFORMATION**

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SS#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELLULAR: \_\_\_\_\_ PLEASE CIRCLE PREFERRED CONTACT NUMBER

MARITAL STATUS: M D S W SEP

REASON FOR VISIT: \_\_\_\_\_

OTHER AREAS OF CONCERN/OR PROCEDURES YOU ARE INTERESTED IN SUCH AS:

Fine Lines and Wrinkles  Major Lines around nose and mouth  Skin texture/Skin Tone

Spider Veins  Unwanted Hair  Bags under eyes or eyelids  Breasts

Excess fullness/loose skin in ABS  Excess fullness in the hips, thighs or buttocks regions

Lip Size or Shape  Other \_\_\_\_\_

REFERRED BY:      Newspaper      Magazine Ad      Phone Book      Previous Patient  
                         Internet      Physician      Other

PLEASE LIST REFERRAL NAME/LOCATION: \_\_\_\_\_

**EMERGENCY CONTACT**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

**PATIENT'S EMPLOYER INFORMATION**

EMPLOYER: \_\_\_\_\_ PHONE# \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## HEALTH HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ Marital Status: \_\_\_\_\_

What is the reason for your visit: \_\_\_\_\_

**MEDICAL HISTORY:** Do you, or have you had any of the following?

	Yes	No		Yes	No
Rheumatic Fever/Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Skin Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Skin Sensitivity to Adhesive Tape	<input type="checkbox"/>	<input type="checkbox"/>	Large Scars or Keloids	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had psychiatric problems/been under the care of a psychiatrist?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any question, please explain: \_\_\_\_\_

**HOSPITALIZATIONS AND/OR PREVIOUS SURGERY:** Please list with dates:

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:** Are you allergic to any medications? Yes No If yes, please list medication and type of reaction (s) \_\_\_\_\_

**MEDICATIONS:** Please list **all medications** you are currently taking, including herbal medicines, diet pills, accutane and over-the-counter medications. \_\_\_\_\_

**FAMILY HISTORY:**

Check (x) if blood relatives have had any of the following:

- |                          | Relationship to you       |   |
|--------------------------|---------------------------|---|
| <input type="checkbox"/> | Breast Cancer _____       |   |
| <input type="checkbox"/> | Skin Cancer _____         | Type of skin cancer if know _____                   |
| <input type="checkbox"/> | Other skin diseases _____ | Type if known _____                                 |
| <input type="checkbox"/> | Keloid Scars _____        | <input type="checkbox"/> Diabetes _____             |
| <input type="checkbox"/> | Bleeding Disorders _____  | <input type="checkbox"/> Heart Disease/stroke _____ |
| <input type="checkbox"/> | Prolonged Bleeding _____  | <input type="checkbox"/> Other _____                |

**HEALTH HABITS:** Do you smoke? No  Yes  \_\_\_\_\_ per day

**WORK STATUS:** Are you currently working? Yes Occupation: \_\_\_\_\_  
No Retired

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for errors or omissions that I may have made in completion of this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

**Lucian J. Rivela, M.D., P.A.**

**Patient Consent and Acknowledgement of Receipt of Privacy Notice**

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease. the restrictions requested.

**I hereby authorize Dr. Lucian J. Rivela, M.D., and/or staff to release information pertaining to my condition and/or care to only those family members (representative) and/or others involved with my care as listed below:**

---

Name (Authorized Representative)	Relationship
----------------------------------	--------------

**I authorize Lucian J. Rivela M.D. and his staff to contact me (or my personal representative in the following ways. \*\*\*\*\*Please check all that apply\*\*\*\*\***

- |                                |                              |                                 |                                    |                              |                             |
|--------------------------------|------------------------------|---------------------------------|------------------------------------|------------------------------|-----------------------------|
| <input type="checkbox"/> Phone | <input type="checkbox"/> Fax | <input type="checkbox"/> E-Mail | <input type="checkbox"/> U.S. Mail | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (Office Promotions)            |                              |                                 | (Office Promotions, Etc.)          |                              |                             |

**E-Mail Address:** \_\_\_\_\_

---

Patient's Signature	Date
---------------------	------

- If not signed by patient, please indicate relationship:
- ( ) parent or guardian of minor patient under 12 years old
  - ( ) guardian or conservator of incompetent patient