

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

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

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SS# (OPTIONAL): \_\_\_\_\_

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

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

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

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

PHARMACY PHONE 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 ☐ Age Spots/Sun Spots

☐ 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: \_\_\_\_\_

I understand the procedure (s) I seek will be cosmetic in nature. I further understand that Dr. Rivela will not accept insurance for this (these) procedure (s) since they are cosmetic procedures. I understand I will be fully responsible for all of the surgical fees for the surgery/treatment that I seek and understand this consent is irrevocable and final.

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"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Skin Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<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"/>			

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. Rivela and his staff to release information pertaining to my condition and/or care to only those family members or authorized representative as listed below:**

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Name of Family Member or Authorized Representative	Relationship
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**I authorize Dr. Rivela and his staff to contact me and/or my family member/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 :** \_\_\_\_\_ ( Please Print Clearly)

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Patient's Signature	Date
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If not signed by patient, please indicate relationship:

- ( ) parent or guardian of minor patient under 12 years old  
( ) guardian or conservator of incompetent patient

**Rivela Plastic Surgery**  
**9191 Pinecroft, Suite 150, The Woodlands, Texas 77380**

**PATIENT SKINCARE AND LASER ASSESMENT FORM**

PATIENT'S NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

**PERSONAL HISTORY**

Are you currently seeing a physician for **any** reason? Yes No  
If yes, explain reason \_\_\_\_\_

Have you **ever** seen a physician or technician **specifically** for a skin problem or skincare? Yes No  
If yes, when and for what reason \_\_\_\_\_

Do you have any health problems? Yes No  
If yes, please list \_\_\_\_\_

Please list **any** medications you are allergic to. YES No  
\_\_\_\_\_

Do you currently take **any** medications? Yes No  
If yes, please list \_\_\_\_\_

How do you want to improve your skin \_\_\_\_\_

**Do any of the following conditions relate to you?**

Accutane or other similar medications - Retin-A, Tazorac, Benzoyl Peroxide, Metrogel, Efudex, Cortisone, etc.	Yes	No
Allergies or skin sensitivities	Yes	No
Autoimmune disease, HIV, Lupus, Hepatitis	Yes	No
Blood thinner — Heparin, Coumadin, Warfarin, etc.	Yes	No
Cancer or post-cancer treatments	Yes	No
Cardiovascular problems	Yes	No
Cold sores or fever blisters	Yes	No
Cortisone or steroid injections	Yes	No
Cosmetic injections, fillers or implants, (i.e. Botox, collagen)	Yes	No
Eczema, psoriasis	Yes	No
Enlarged or painful glands	Yes	No
Epilepsy	Yes	No
Heart Ailment	Yes	No
Hypertension or high blood pressure	Yes	No
Moles, warts, keloids, pigmented scars, icepick scars	Yes	No
Light sensitive medication	Yes	No
Loose, thin, aged skin	Yes	No
Oily or Acne prone skin (blac kheads, whiteheads, large pores, cysts, etc.	Yes	No
Pacemaker or metal implants	Yes	No
Phlebitis, varicose veins	Yes	No
Rosacea, telangiectasia/couperose	Yes	No
Type 1 Diabetic	Yes	No
Problems healing from a cut or burn	Yes	No

**FREE RADICAL EXPOSURE**

Do you smoke?	Yes	No	How much? _____
Do you consume alcohol?	Yes	No	How much? _____
Do you have a healthy diet?	Yes	No	List any dietary concerns: _____
Do you exercise?	Yes	No	How much? _____
Do you take Vitamins?	Yes	No	Multi-Vitamins: _____ Antioxidants: _____

**FOR WOMEN ONLY**

Are you going through menopause?	Yes	No
Are you pregnant or lactating?	Yes	No
Have you ever been pregnant?	Yes	No
If yes, during pregnancy did you ever experience hyperpigmentation or “pregnancy mask”?	Yes	No
Do you have regular periods?	Yes	No
When was your last menstrual period? _____ n/a _____		

**PIGMENTATION (Fitzpatrick Scale)**

How do you tan?

I Burn \_\_\_\_\_ II Usually Burn \_\_\_\_\_ III Sometimes Burn \_\_\_\_\_ IV Rarely Burn \_\_\_\_\_ V Never Burn “Brown” \_\_\_\_\_ VI Never Burn “Black” \_\_\_\_\_

Hair Type: Coarse \_\_\_\_\_ Fine \_\_\_\_\_ Comments: \_\_\_\_\_

Natural Hair Color: Black \_\_\_\_\_ Brown \_\_\_\_\_ Red \_\_\_\_\_ Blonde \_\_\_\_\_ Gray \_\_\_\_\_ Other \_\_\_\_\_

Presence of tattoos: \_\_\_\_\_ Location: \_\_\_\_\_

Frequency of use of the following modalities:

Waxing \_\_\_\_\_ Mechanical epilation (plucking) \_\_\_\_\_ Electrolysis \_\_\_\_\_ Bleaching \_\_\_\_\_

Tanning history: \_\_\_\_\_

What specific areas do you want to treat?

Neck \_\_\_\_\_ Face \_\_\_\_\_ Chest \_\_\_\_\_ Back \_\_\_\_\_ Other \_\_\_\_\_

Patient Signature: _____	Date: _____
Technician Signature: _____	Date: _____

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Relationship

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(Office Promotions)

U.S. Mail

☐ YES ☐ NO

(Office Promotions, Etc.)

**E-Mail Address :** \_\_\_\_\_ ( Please Print Clearly)

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Patient's Signature

Date

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