DAHIYA
Facial Plastic Surgery & Laser Center

DAHIYA FACIAL PLASTIC SURGERY AND LASER CENTER
CONSULTATION AND MEDICAL HISTORY

Name _____ Date of Birth _____

Today's Date_____

Address:

_____

Street City State Zip

Home phone: _____ May we contact you on your home phone? YES ☐ NO ☐

Cell phone: _____ May we contact you on your mobile phone? YES ☐ NO ☐

Email: _____ May we send appointment reminders to your email? YES ☐

NO ☐

Preferred Method of Contact (circle one): Home phone / Mobile phone / Email

How were you referred to us?

_____

Emergency Contact: _____ Relationship_____ Phone

#_____

If anyone, may we have your authorization to release your medical information if they should contact us?

Name_____Relationship_____

_____

WHICH SURGICAL PROCEDURES ARE YOU INTERESTED? (Circle response)

Face or Mini Lift ☐	Rhinoplasty ☐	Eyelid Lift ☐	Bellafill ☐	Injectable Fillers Liquid Facelift ☐	Botox ☐	CO2 Laser Resurfacing ☐
Fat Transfer Liposuction ☐	Ear Lobe Surgery ☐	Brow Lift ☐	Scar Revision ☐	Hair Restoration PRP ☐	Lip Augmentation ☐	Hormonal Replacement Therapy ☐
Chemical Peel Microdermabrasion Micro-needling ☐	Removal of cysts/moles, etc. ☐	Other:				

If for cosmetic purposes, what specifically, do you wish to have corrected: (i.e. what don't you like about the above condition(s)?

_____

_____

When did you begin to consider surgical correction? _____ Have you discussed this surgery with your family? Yes/No

MEDICAL HISTORY (circle appropriate response)

No/ Yes Are you now taking any drugs or medications, including hormone replacement therapy, vitamins, nutritional supplements, green tea, herbs, etc? List names and dosages

_____

_____

_____

No/ Yes Are you allergic to any prescription medications or allergic to latex, creams, tape, make-up, etc.? List your reaction (hives, swelling, nausea, etc):

_____

_____

When was your last physical examination?

_____

List your Primary Care Physician: _____Telephone

_____

SURGICAL HISTORY

Please list any previous surgical procedures with approximate date performed (including skin surgery, teeth/gums, heart, abdomen, reproductive system, lasik or eye surgery):

_____

Have you had previous cosmetic, plastic or reconstructive surgery? **Yes/No** When, and what was done?

_____

_____

If you have had previous cosmetic surgery, were you satisfied with the results? _____If not, why?_____ _____ Where was the surgery performed?

_____

Were there complications? **Yes / No** Problems with Anesthesia? **Yes / No** Did you have a normal recovery? **Yes/ No**

Has anyone in your family or a close friend had cosmetic or reconstructive surgery performed by Dr. Ravi Dahiya?

_____

_____

What was done?

_____

FAMILY HISTORY

Do you or any family members have: (indicate who)
Heart trouble_____ Excessive bleeding tendencies_____ Psychiatric or "nerve" problems_____
High blood pressure_____ Diabetes_____
Thyroid problems_____
Excessive bruising _____ Excessive scarring_____
Delayed or poor healing_____

No☐Yes☐ Migraines?
No☐Yes☐ Hay fever, nasal allergies or asthma?
No☐Yes☐ Vision changes or problems with your eyes? Explain_____
No☐Yes☐ Chest Pain with exertion? Explain
No☐Yes☐ Heart problems? Explain_____
No☐Yes☐ Reflux or ulcers?
No☐Yes☐ Sleep Apnea?
No☐Yes☐ Liver, gall bladder trouble, "yellow jaundice", or hepatitis?
No☐Yes☐ Kidney or bladder problems? Explain_____
No☐Yes☐ Arthritis or autoimmune conditions (lupus, scleroderma, etc)?
No☐Yes☐ Do you ever experience poor circulation in your fingers or toes?
No☐Yes☐ Do you have frequent skin infections, irritations or rashes? Circle which one(s)
No☐Yes☐ Frequent fever blisters or cold sores?
No☐es ☐ History of stroke or heart attack? Explain_____
No☐Yes☐ Dizzy spells?
No☐Yes☐ Has any part of your body ever been paralyzed or numb?
Explain_____

No Yes Have you every been diagnosed with HIV/AIDS?
No Yes Anemia or blood disorders?
No Yes Thyroid disease?
No Yes Smoke or use nicotine in any fashion (patches, gum, etc)?
No Yes Drink more than two alcoholic drinks a day?
No Yes Have you ever received treatment for abuse of alcohol or drugs?
Explain_____
No Yes Do you usually feel unhappy, depressed, or tired?
No Yes Have you ever had a "nervous breakdown"?
Explain_____
No Yes Do you take medication for anxiety?
No Yes Have you ever considered consulting a psychiatrist, psychologist or counselor? Explain
_____
No Yes Have you ever been under the care of a psychiatrist or psychologist?
Explain_____

If you are a woman, are you still having periods? **Yes/No** Are you pregnant or trying to get pregnant? **Yes/No**
If you are a man, have you ever had prostate problems? **Yes/No**
If you have any other health problems that have not been covered, please explain:
_____
_____
_____

No Yes Do you accept the fact that every medical and surgical treatment is associated with risks and other imponderables?
No Yes Do you agree to comply with the pre and post treatment instructions while you are under their care?

SOCIAL HISTORY

No Yes Do you drink alcohol?
No Yes Do you currently smoke?
No Yes Have you smoked in the past?
No Yes Do you use recreational drugs?

For current smokers: I understand that smoking affects the blood supply to my tissues, which places me at increased risk for prolonged
wound healing, blistering, and/or actual skin and tissue loss.

Signature x_____

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CANCELLATION AND NO SHOW POLICY

We understand that situations may arise in which you must cancel your appointment. It is therefore requested, that if you must cancel your appointment, please provide us with more than 48 hours' notice. Office appointments which are cancelled with less 48 hours notification may be subject to a cancellation fee. Patient who do not show up for their appointment as scheduled without a call to cancel will be considered a no show and may be subject to a no show fee. If an appointment is not cancelled in a timely manner, it leaves us insufficient time to adjust our schedule, and prevents another patient from getting needed treatment.

Failure to cancel your appointment in a timely manner will result in the following payment prior to rescheduling:

Appointment with Dr. Dahiya -- $150 cancellation or no show fee
Appointment with nurses --$75 cancellation or no show fee

Rescheduling: We understand that delays can happen. However, due to the nature of our business, if a patient arrives more than 15 minutes late, we may need to reschedule the appointment.

Account Balances: It is our office policy that patients with an outstanding balance or past-due balance must pay their account balance in full prior to receiving further services by our practice.

Patients who have questions about these policies or their account are encouraged to call the office and speak to our office manager.

Your appointment is very important to us and our practice firmly believes that a good relationship is based on understanding and good communication. We appreciate your understanding. Thank you for being a patient of Dahiya Facial Plastic Surgery and Laser Center.

By signing this document, I understand the cancellation, no show and other policies for Dahiya Facial Plastic Surgery and Laser Center.

Signature_____Date_____

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HIPAA INFORMATION AND CONSENT FORM

The Dahiya Center for Facial Plastic Surgery is required by law to maintain the privacy of our patients and to provide individual with this notice with respect to protected health information. If you have any concerns or objections to this form, please ask a staff member for further details about HIPAA compliance requirements.

I request that my Protected Health Information be discussed with and released to the parties that I designate below: (select all that apply)
☐ Parents or Legal Guardian
☐ Spouse
☐ Other Family Members(s)
Please list: _____
☐ My Protected Health Information (PHI) is to be discussed with me only

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signed_____Date_____

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Scheduling Surgery:

When you ask us to schedule surgery for you, we must do several things, long before the day of your surgery.
1. Reserve the operating room
2. Order and pay for any surgical supplies or implants that are needed for your surgery
3. Secure the necessary specialized surgical nurses and surgical technicians that will be needed, and/or provide coverage to free them up from their
other responsibilities.
4. Prepare the required equipment and sterilize the necessary instruments.
5. We must turn down every other patient who wants surgery on the day and time we have reserved specifically for you.

Because of these financial and time commitments we must make, we ask that you be definite about your desire for surgery, and be certain that you
have the funds available and care taker/travel accommodations scheduled before asking us to schedule your surgery.

• Elective cosmetic procedures are not covered by insurance.
• The cosmetic consultation is complimentary.
• A deposit is required to book your surgery (this fee holds your date & time of surgery).
• The balance is due in full 7 business days prior to the date of surgery.
• We provide different payment options, which may be used individually, or combined (Cash, Check, Visa, MC, Amex, and Financing Plans).

Cancellation/Rescheduling Policy:

• We understand that a situation may arise that could force you to postpone your surgery. Please understand that such changes affect not you're your surgeon but other patients as well. The surgeon's time, as well as that of the operating room staff, is valuable and we request your courtesy and concern.
• You may reschedule your surgery once at no charge, with at least 7 days' notice. Your deposit will be applied to your rescheduled date.
• Should you need to reschedule your surgery again, there will an additional $500 fee to do so.
• If you cancel your surgery within 7 days prior to surgery, the deposit is nonrefundable a cancellation fee of $1,000 will be charged. We will refund any additional payments that have been paid.

Other Charges:

• Some surgeries are performed in the hospital or outpatient surgery centers. Please be aware that the hospital and anesthesia fees are separate
expenses. If your surgery is taking place at the Chevy Chase Surgery Center, the operating room and anesthesia fees must be paid in full 7 days prior
to the date of surgery.
• If you require a revisionary procedure, the operating room fee would be your responsibility. There may be an additional fee for the surgeon depending on the revision that is necessary.

Agreement: I have read thoroughly, understand and agree to the above policies and conditions.

Signature:_____Date:_____

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