JOSEPH C. BANIS JR M.D. P.C.

(502) 589-8000

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Do you have Text Messaging? ☐ No ☐ Yes

Any restrictions for contacting you? ☐ No ☐ Yes E-mail _____

Preferred Method of Contact: _____ (Appointment confirmations are also sent via Text Messaging.)

Age _____ Birthdate _____ SS# _____ Gender ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married to: _____ ☐ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ☐ Yes ☐ No

Address _____
Street & Suite # City State Zip

How did you hear about Dr. Banis? (Mark all that apply)

☐ TV News ☐ TV Ad ☐ Phone Book ☐ Magazine ☐ Newsletter ☐ Seminar ☐ Salon ☐ Web

☐ Friend/Relative: _____ ☐ Doctor: _____ ☐ Other: _____

If you were referred by a specific person, may we thank them? ☐ Yes ☐ No

Physician Contact

Primary Care Doctor

First & Last Name: _____

Telephone: _____

Referring Doctor

First & Last Name: _____

Telephone: _____

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Pharmacy

Name _____ Phone # _____

Do you have a living will? ☐ Yes ☐ No If you need information please ask a staff member.

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Banis to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Banis and myself.

Signature _____ **Date** _____

Joseph Banis, MD
PLASTIC SURGERY
MEDICAL SKIN CARE

Skin Care Evaluation

SKIN CARE SOLUTIONS

Name: _____ Age: _____ Date: _____

Referred by: _____ Dermatologist: _____

Patient History

Are you pregnant, lactating, or planning to become pregnant? ☐Yes ☐No Are you using oral contraceptives? ☐Yes ☐No

Menopause? ☐Yes ☐No Are you using hormones? ☐Yes ☐No History of hormone imbalance ☐Yes ☐No

Have you ever used Accutane? ☐Yes ☐No Last dose? _____

Current Medications: _____

_____

Current Skin Care Products: _____

Have you ever had an allergy to any medications or skin products/cosmetics? ☐Yes ☐No _____

Skin Conditions/History Of

☐Skin Cancer	☐Pre-cancerous Lesions	☐Sebaceous Hyperplasia
☐Eczema	☐Psoriasis	☐Dermatitis
☐Keratosis Pilaris	☐Rosacea	☐Fever Blisters/Cold Sores
☐Hepatitis	☐Keloids	☐ _____

Have you had a chemical peel in the past? ☐Yes ☐No _____

Have you had laser resurfacing in the past? ☐Yes ☐No _____

Objectives

☐Minimize Pore Size	☐Diminish Redness/Capillaries on Face	☐Lighten Hyperpigmented Areas
☐Smooth Skin Texture	☐Restore Skin Elasticity	☐Eliminate Excess Skin
☐Diminish Under-Eye Puffiness	☐Diminish Under-Eye Circles	☐Diminish Flakiness of Skin

☐Diminish Fine Lines/Wrinkles Quickly? _____ Over time? _____

☐Undergo Treatments With: ☐No Downtime ☐Minimal Downtime ☐Best Treatment Regardless of Downtime

☐Optimize At Home Skincare: ☐Simple ☐Complete

☐Fuller Lips	☐Diminish Cellulite	☐Clear Acne Eruptions
☐Clear Blackheads	☐Decrease Oiliness	☐Improve Acne Scarring

Joseph Banis, MD
AESTHETIC & RECONSTRUCTIVE SURGERY
Dr. Joseph Banis & Dr. Vera van Aalst

Skin Care and Peel Informed Consent

Dr. Banis and/or Dr. van Aalst and their trained staff may recommend that you begin using a pharmaceutical skin care line and/or begin an in-office treatment program to help improve the appearance of your skin. Therefore, it is very important that you have a thorough understanding of what these can and cannot do for your particular skin condition. In addition, it is important that you understand the potential risks associated with these skincare lines and procedures.

Before subjecting yourself to any pharmaceutical skin care products or in-office skin care procedures (referred to as "Treatment" below), read carefully the following statements. After you have read each statement, please initial your understanding of each respective statement in the space that has been provided.

_____ The Treatment has been explained to me in detail by the physician and/or members of the physician's staff.

_____ I understand that the Treatment is a skin rejuvenation treatment and that I may need several administrations of the Treatment in order to achieve my best results.

_____ I understand that for optimum results, a home treatment program is needed to enhance the results of in-office Treatment.

_____ I understand that Treatments need not be administered by a physician. It is also my understanding that, in addition to receiving formal training, any non physician medical assistant (i.e. RN, LPN, Medical Assistant, Surgical Technician, Cosmetologist or Aesthetician) who administers Treatments has had his/her skills reviewed and endorsed by the supervising or attending physician.

_____ I understand that it is extremely important to strictly follow all home care instructions when striving for optimal results.

_____ I have read and accept the possible side effects with any Treatment.

_____ Discomfort: This is usually minimal and of short duration.

_____ Swelling: This is very unusual, but if it occurs will be minimal and subsides in a few hours to a few days.

_____ Reddening: A red discoloration may persist anywhere from a few days to several weeks.

_____ Demarcation: Refers to the difference in color, texture or pigmentation that may occur at the junction between the treated and non-treated skin areas.

_____ Existing Blemishes: Moles, blood vessels (telangiectasias), freckles and sun spots may become more obvious and darker since the layers of dead skin have been removed.

_____ Eye Injury: If chemicals get into the eye, scarring and vision disturbances may occur. Protective safety glasses should be worn while chemicals are being used.

_____ Scarring: Is very unusual, but may occur.

_____ Pigmentation: Although extremely rare, temporary and possibly permanent changes in the color of the skin may occur.

_____ Milia: May occur, but will usually disappear quickly.

_____ Infection: Is extremely rare, but may occur. An outbreak of herpes may occur in affected individuals (you may need to be treated with an anti-viral prior to any peels if you are prone to cold sores).

_____ Hair Growth: If the dermaplanning phase of the MicroPeel is administered, hair is expected to grow back blunt-ended. New hair will not appear darker or denser. However, I do understand that any hormonal imbalance that may be present within my anatomical system can alter the normal hair growth pattern and cause a darker and denser restoration process.

_____ I understand that if I experience any adverse side affects that appear to be attributable to my use of home care products, I would discontinue use of the products and notify the office.

I certify that I have read, understand and accept ALL of the above.

Patient Signature: _____ Date: _____
(Printed Name): _____

Witness Signature: _____ Date: _____

Joseph C. Banis MD
Aesthetic and Reconstructive Surgery

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read the Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the form. I also understand my rights to access and control such protected health information.

Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

FOR OFFICE USE ONLY:

If patient did not return receipt, document "good faith effort" to provide patient with this notice and reason receipt was not obtained.

Signature of MD or
Privacy Officer: _____ **Date:** _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to an individual's office instead of to their home.

I wish to be contacted in the following manner (check all that apply):

☐ Home telephone_____
- ☐ OK to leave message with detailed information
- ☐Leave message with call-back number only.

☐ Work telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ OK to mail to my home address
- ☐ OK to fax to my work/office
- ☐ Please mail all correspondence to:

_____

_____

_____

☐ Other _____

You may disclose my information to the following people (family and friends only – you do not need to list other Healthcare Providers on this form):

_____ _____
Name Phone #

_____ _____
Name Phone #

_____ _____
Name Phone #

_____ _____
Patient Signature Date

_____ _____
Print Name Date