PARBHU OCULOFACIAL
PLASTIC SURGERY

Name:____ Date:__________________

Last First MI

Mailing Address:____

Date of Birth:__________________________ Age:__________ Sex:☐ Female ☐ Male

Home Phone: (______)__________________

E-Mail: ______________________________

Pharmacy Address/Phone:____

Emergency Contact:____

Who may we thank for you coming to our office? ☐**New Beauty Magazine** ☐**Haute Living Magazine** ☐**Facebook** ☐**Instagram** ☐**Other**

Do you have any major medical problems or serious illnesses? ☐ Yes ☐ No

If so please list:____

Please list all prior surgical procedures and dates performed:_______________________

____

Please list all past injectable procedures (Botox, Juvederm, Restylane, Collagen, etc.) and dates performed:______________

____

____

Have you ever had an adverse reaction to any cosmetic treatment? If so please list:__________________

____

Do you have any allergies to medications or otherwise? If so please list:______________________

____

Please list any systemic medications you take, prescription and over the counter:_______________

____

____

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Are you pregnant, trying to become pregnant, or nursing? ☐ Yes ☐ No

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Financial Agreement

I understand that I have the primary duty and obligation to pay my Doctor for her services and am responsible for the full cost of any cosmetic procedures or treatments. There are no refunds after a procedure is completed. The practice only accepts payments in the forms of cash or credit card. Any other form of payment, including check is not accepted.

______________________________________ ____________________

Patient (or Authorized persons) Signature **Date**

ORLANDO EYE INSTITUTE
Your Eyes are in Good Hands

PARBHU OCULOFACIAL PLASTIC SURGERY

Review of Symptoms (circle if it applies to you)

EYES

Previous Surgery
Contact Lens
Pain
Double Vision
Glaucoma
Macular Degeneration
Cataracts
Dry Eyes

RESPIRATORY

Cough
Congestion
Wheezing
Asthma
COPD
Emphysema
Sleep apnea (If yes, do you wear CPAP? Yes/No

BLOOD/LYMPH NODES

Easy Bruising
Gums Bleed Easily
Prolonged Bleeding
Heavy Aspirin Use
HIV/ AIDS
Hepatitis
Tuberculosis

EAR, NOSE, and THROAT

Hard of Hearing
Ringing in the Ears
Vertigo

GASTROINTESTINAL

Heartburn
Nausea/Vomiting
Jaundice/Hepatitis

MUSCULOSKELETAL

Stiffness
Arthritis
Joint Pain/Swelling

PSYCHIATRIC

Bipolar
Anxiety/Depression
Mood Swings
Difficult Sleeping

GENITO-URINARY

Pain/Difficulty
Blood in Urine
History of Kidney Stones
History of STD's

SKIN

Rash/Sores
Lesions
Hives/Eczema
Abnormal Scaring
MRSA/Staph Infection

CARDIOVASCULAR

Chest Pain
Dizziness
Fainting Spells
Shortness of Breath
Hypertension
Irregular Heartbeat
Difficulty Lying Flat

ENDOCRINE

Increased Thirst/ Hunger
Increased Urination/ Sweating
Diabetes
Thyroid
Fingernail Changes

NEUROLOGICAL

Seizures
Weakness/Paralysis
Numbness
Tremors
Seizers

CONSTITUTIONAL

Fatigue/Weakness
Fever
Weight Gain/Loss

IMMUNOLOGIC

Hives
Itching
Runny Nose
Sinus Pressure

List previous surgeries: ____

List of allergies: ____

Have you received a Flu shot this year? Yes______ No ____ Has the patient had more than 2 falls in the past year? Yes__ No___

Have you received the pneumonia vaccine this year? Yes_____No______ Smoking status: ___Never_______Former_____Current everyday

Alcohol? ____Yes ___ No _____ If yes, how much? ____

Drugs? Yes_____No_____ If answered yes, which ones?_____How much?_____How long?_______ When did you quit?___________

This information is accurate to the best of my knowledge

Guardian/Patient Signature:_____________________________________ **Date:**___________________

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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH/MEDICAL INFORMATION PURSUANT TO HIPAA (Health Insurance Portablity and Accountablitiy Act of 1996)

I authorize the release of my Protected health Information to the following person(s) or organization who can call on my behalf. I authorize disclosing of all my medical records received or created by the Practice. All images/photography of my eye(s), and Billing/Account information to (please complete):

Name:____Relationship:____________________________________
Name:____Relationship:____________________________________
Name:____Relationship:____________________________________
Name:____Relationship:____________________________________

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

When you Protected Health Information is released as provided in this Authorization, the recipient may not have a legal obligation to protect it's confidentiality and may re-disclose it.

Expiration of this Authorization:

This Authorization will automatically expire if I sent in a written request. And I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

You rights with respect to this Authorization:

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization.

If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to Parbhu Oculofacial Plastic Surgery, to our physical or email address. The revocation will not have any effect however, on actions taken in reliance on the Authorization prior to your revocation.

BY MY SIGNATURE I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I MA SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

____________________________________ ____________________________

Patient Signature **Date**

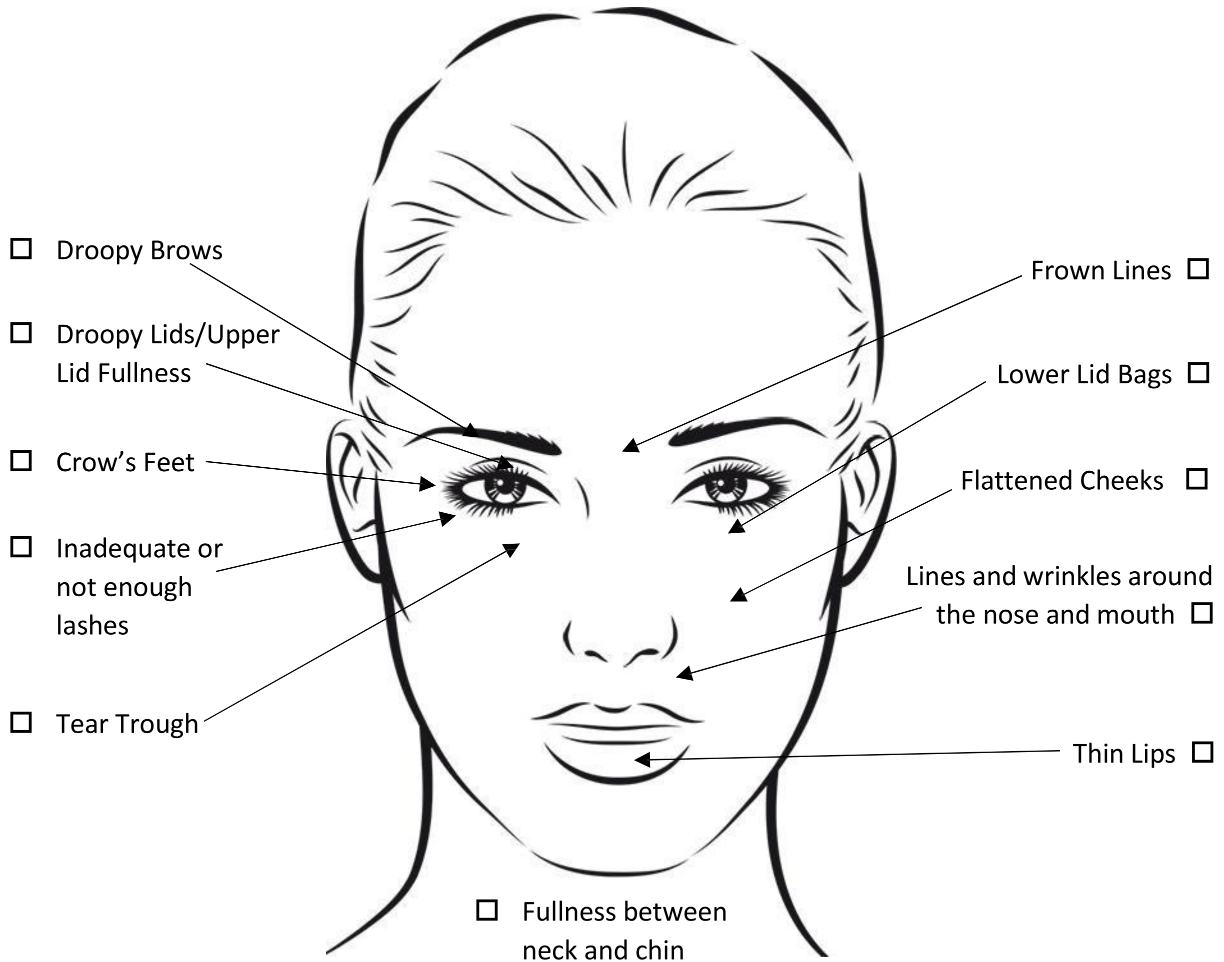
Self Assessment

Name:____**Date of Birth**:____________**Date**:_____________

What brings you in today? ____

Select which areas of the face concern you in the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Please complete and return this form to the front desk before your consultation.

Name: Age: Date: / /

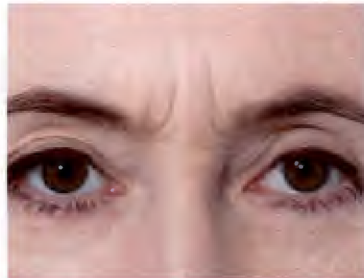
Please indicate any areas of concern for you

Check all that apply.

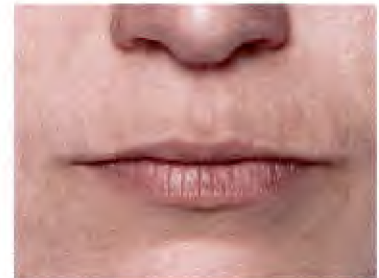
☐ Forehead lines

☐ Lip appearance and texture

☐ Frown lines



☐ Thin lips



☐ Crow's feet lines

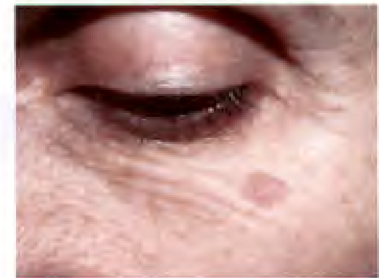
☐ Double chin

☐ Flattened cheeks/ sunken cheeks

☐ Thinning or inadequate lashes

☐ Lines and wrinkles around the nose and mouth

☐ Skin appearance and texture



Be sure to bring this to your aesthetic specialist for your assessment.

Aesthetic specialist: See the next page to create the patient's treatment recommendations.

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Consent for Use of Photographs/Videos

I, ____, give my informed and voluntary consent to Keshini Parbhu, MD and/or her associates to take photographs and/or video of me pre-operatively, intra-operatively, and post-operatively. I understand that these photographs and/or videos will be shown to the general public which includes current and prospective patients. I understand entirely that this authorization is completely voluntary and that people may recognize my face. I understand that any disclosure of information has the potential of unauthorized disclosure and that information may or may not be protected by applicable federal and/or state confidentiality rules. Dr.Keshini Parbhu and or any representative cannot guarantee, nor have liability should you disclose any identifying factors to a third party as they may not be required to maintain your privacy.

Parbhu Oculofacial Plastic Surgery has my permission to utilize my photos, videos and/or testimonials on:

1. Official clinic social media accounts including Snapchat, Instagram, and Facebook (account names shown below)
2. During consultations with patients
3. In a patient information brochure or album, and/or online
4. As part of an advertisement which may appear in newspaper, magazines, billboards, or other conventional media

If you object to having your photo shared on any of the above please specify:

____

Signature: ____ Date: ______________

We greatly appreciate your willingness to participate. Please visit us on social media!

fb.com/ParbhuMD ParbhuMD @ParbhuMD

YouTube