

PATIENT INTAKE

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____ Email: _____

Emergency Contact Name: _____ Phone #: _____

Occupation: _____

How did you hear about us? _____

Liposuction Areas you are interested in treating.

- | | |
|---|--|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Inner thigh |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Outer thigh |
| <input type="checkbox"/> Upper Back/Axilla | <input type="checkbox"/> 360' Thighs |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Knee Complex |
| <input type="checkbox"/> Hip/Waist/Mid Back | <input type="checkbox"/> Calves/Ankles/Knees |
| <input type="checkbox"/> Chin/neck | |

What Liposuction Areas you have already had done? (Date Performed)

- | | |
|---|--|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Inner thigh |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Outer thigh |
| <input type="checkbox"/> Upper Back/Axilla | <input type="checkbox"/> 360' Thighs |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Knee Complex |
| <input type="checkbox"/> Hip/Waist/Mid Back | <input type="checkbox"/> Calves/Ankles/Knees |
| <input type="checkbox"/> Chin/neck | |

What Plastic Surgery Procedures you have had done? (Date Performed)

- | | |
|---|---|
| <input type="checkbox"/> Arm Lift/Brachio | <input type="checkbox"/> Gynecomastia/Male Breast |
| <input type="checkbox"/> Rhinoplasty | <input type="checkbox"/> Breast Aug/Implants |
| <input type="checkbox"/> Thigh Lift | <input type="checkbox"/> Breast Lift/Reduction |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Tummy Tuck |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Face/Neck Lift |

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Are you interested in being treated for Lipedema or Cosmetic purposes? _____

Have you had Non-Invasive fat reduction procedures (ie, CoolSculpting, sculpture etc.)

How long ago was it performed and in what area?

Have you had a large weight loss, if so how much did you lose and when?

Do you have skin looseness in areas you want lipo done? **Yes Or No**

Do you have any major medical issues? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Autoimmune/Lupus/MS | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Cancer | |

Allergies: _____

Height _____

Weight _____



Artlipo Plastic Surgery
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**Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information**

PATIENT NAME

DATE

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Artlipo Plastic Surgery may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Artlipo Plastic Surgery has a detailed document called the '**Notice of Privacy Practices**'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the '**Notice**' before signing this agreement. If I ask, Artlipo Plastic Surgery will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Artlipo Plastic Surgery to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Artlipo Plastic Surgery has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative)

DATE

Relationship to Patient if signed by another party

DATE

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our '**Notice**' at any time by contacting: Artlipo Plastic Surgery 12634 Bassbrook Lane, Tampa, FL 33626.