JONATHAN A. HOENIG, MD
OCULOFACIAL PLASTIC & RECONSTRUCTIVE SURGERY

9735 WILSHIRE BLVD, STE 308, BEVERLY HILLS, CA 90212   310.247.3777
15503 VENTURA BLVD, STE 370, ENCINO, CA 91436   818.501.4550

Date ______________________

PATIENT INFORMATION

First Name ________________________ Middle Initial _______ Last Name _______________________

Date of Birth ____/____/_______ Age ______ Sex: M / F   Marital Status: M S D W P

Soc. Sec. No. _______-______-______ Occupation_______________ Employer__________________

Home Street Address ____

Home City, State, Zip Code ____

Preferred Contact #: Cell Home Work   Cell Phone ____________________________

Home Phone___________________leave msg? Y/N Work Phone ________________ leave msg? Y/N

Email Address ____________________________ **Add to E-Mail List for newsletter & specials? Y / N**

Emergency Contact: ____________________________Relation_____________ Phone ______________

How did you hear about our practice?

Doctor: _______________ Friend/Family: ___________________ Internet/Website:_______________

INSURANCE INFORMATION (you may leave blank if you are *only* having cosmetic procedures)

Subscriber Name ________________________________ Relation to Patient _______________________

Subscriber's SSN _______-______-______ Date of Birth _____/_____/______Phone ______________

Primary Insurance ________________________ Policy # __________________ Gp # _______________

Secondary Insurance _____________________ Policy # __________________ Gp # _______________

I hereby authorize my insurance benefits to be paid directly to Jonathan Hoenig, MD. I agree that I am responsible for copayments, deductibles, and non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers for the purpose of billing.

Print Full Name _____________________________ Signature __________________________ Date _________

REASON FOR VISIT:

Main Reason:____

Other Concerns / Areas of Interest: *(check all that apply)*

_____ Forehead Lines
_____ Frown Lines
_____ Crows Feet
_____ Low Eyebrows
_____ Droopy Eyelids
_____ Excess Eyelid Skin
_____ Under Eye Bags
_____ Under Eye Darkness
_____ Angry / Tired Look
_____ Sunken Cheeks
_____ Thin Lips

_____ Jowls
_____ Sun Damage
_____ Brown Spots
_____ Fine Lines / Wrinkles
_____ Skin Cancer
_____ Sun Protection
_____ Excessive Sweating
_____ Smile Lines
_____ BOTOX Cosmetic®
_____ Skin Fillers/Plumpers

_____ Facelift
_____ Necklift
_____ Cheeklift
_____ Eyelid Lift
_____ Browlift
_____ Lip Augmentation
_____ Lip Lift
_____ Facial Implants
_____ Fat Transfer

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Patient Name ______________________________ Today's Date ____________

MEDICAL INFORMATION

Height _______ Weight ______ For you, is this weight Normal ______ Low _________ High _________

Do you now or have you ever smoked? N / Y How much and for how long? ________________

Do you drink alcohol? Never ________Rarely ________ Frequently _________ Daily ______________

Do you use recreational drugs? N / Y If yes, what types and how often?___________________

Have you have ANY DRUG OR LATEX ALLERGIES, or reactions to any medicines? No / Yes

If yes, please list allergy and reaction: ____

____

Please list any PRESCRIPTION medications you take on a regular or occasional basis:

____

____

Please list any OVER THE COUNTER MEDICATIONS, HERBS OR VITAMINS you take:

____

- Have you or a family member had problems with anesthesia? No / Yes ______________
- When you go to the dentist, do you have a hard time getting or staying numb? No / Yes
- Do you have bruising or bleeding problems? No / Yes ____________________

REVIEW OF SYMPTOMS and MEDICAL HISTORY

Circle any and all of the following symptoms you have or have had in the past year:

weight loss	double vision	hearing loss	bruise easily
fever	dry eyes	ringing in ears	rashes
night sweats	eye redness	sore throat	change in moles
depression	eye pain	bloody nose	scars
heart palpitations	chronic cough	constipation	frequent urination
chest pain	bloody sputum	diarrhea	blood in urine
heart racing	short of breath	blood in stools	painful urination
ankle swelling	wheezing	excessive thirst	lost bladder control
headaches	joint pain	bleeding gums	allergic swelling
dizziness	muscle pain	unexplained bleed	hives
numbness	weak arms/legs	transfusion	other:________

Please circle any and all of the following conditions you have now or have had in the past

HIV + or AIDS	ulcers or heartburn	heart disease
irregular heartbeat	high blood pressure	kidney disease
heart murmur	psychiatric care	asthma or emphysema
heart attack	thyroid problems	tuberculosis
stroke	diabetes	hepatitis or liver disease
seizures	arthritis	alcohol or drug addiction

cancer (please specify type and treatment) ___________________________________

other conditions ____

IF NONE OF THE ABOVE APPLY, PLEASE INITIAL HERE:_____________

Patient Name ________________________________ Today's Date ______________

EYE AND FACIAL HISTORY

Do you have any visual problems?	Y / N	Have you had Bell's Palsy?	Y / N
Do you wear glasses or contacts?	Y / N	Have you had any injury to your eyes?	Y / N
Do you have dry or watery eyes?	Y / N	Have you ever had cataracts?	Y / N
Do you have glaucoma?	Y / N	Have you had laser or other eye surgery?	Y / N

PAST SURGICAL HISTORY (please list all previous surgeries that you have had)

Date ________ Surgery ______________________________ Doctor _________________
Date ________ Surgery ______________________________ Doctor _________________
Date ________ Surgery ______________________________ Doctor _________________
Date ________ Surgery ______________________________ Doctor _________________

CURRENT PHYSICIAN(S)

Name ____ Phone #: _________________
Name ____ Phone #: _________________

Please provide any additional information you think we should know:_________________________

____

I understand that the above answers are important for my safety during and after surgery or medical care and I, therefore, certify that all of the above answers are true to the best of my knowledge.

Print Full Name ___________________________ Signature _________________________ Date _________

PHOTOGRAPHIC CONSENT -*Dr Hoenig cannot perform any procedures without a signed consent*

In connection with the medical services that I am receiving from Jonathan Hoenig, MD, I consent that photographs and/or or videos may be taken of me before and after treatments. These photos or videos may be used for:

- my medical records only _______ (initial)
- my medical records AND any print, visual, or electronic media including but not limited to medical journals textbooks, education and marketing materials, public and private websites, TV shows, and magazines _______ *(optional, initial if yes)*

Print Full Name ___________________________ Signature _________________________ Date _________

CONSULTATION QUESTIONNAIRE

My three (3) biggest concerns are:

the doctor's abilities	looking unnatural	taking time off
the discomfort	telling my spouse or others	the cost
anesthesia	people noticing	the scars

How soon are you interested in receiving your procedure or treatment?________________
Do you have any particular date(s) in mind? Yes / No_______________________________
Are you getting ready for a special event? Yes / No ________________________________
Would you like information on financing options? Yes / No

Occasionally, we have a late notice opening for surgery. Does your lifestyle and schedule allow flexibility to fill that space with 1-2 weeks notice in exchange for a discount on your fees? Yes / No

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Patient Name ______________________________ Today's Date ____________

MISSED APPOINTMENT AND CANCELLATION POLICY

In order to be respectful of the needs of other patients, our office requires a 2 business day notice of cancellation of your appointment. In the event that you miss or fail to cancel one your appointments in a timely manner, a fee of $100 will be charged. This fee must be paid prior to scheduling future appointments.
You may call 310-247-3777 or 818-501-4550 and leave a message or email info@drhoenig.com at any time when you realize that you will be unable to keep your scheduled appointment.
If you arrive more than 20 minutes late, we may have to reschedule your appointment. Exceptions to this policy will be made on a case-by-case basis. Thank you for your understanding.

Credit Card Number ______________________________ Expiration Date ____________

Print Full Name ________________________ Signature ______________________ Date _______

HIPAA ACKNOWLEDGEMENT AND NOTICE OF PRIVACY PRACTICES

This summary of our privacy practices is contains a condensed version of our Notice of Privacy Practices. Our full-length Notice is available for viewing on our website or in the office.

Date of Last Revision: 12/2013 Effective Date: Immediately

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the complete Notice of Privacy Practices):

- For medical treatment
- For appointment reminders
- To obtain payment for our services
- To avert a serious threat to health or safety
- To obtain payment for our services
- In response to requests arising out of lawsuits

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices that follows this summary.

Print Full Name __________________________ Signature ________________________ Date _________