WILLIAM NUMA, MD, FACS
FACIAL PLASTIC SURGERY
38 NEWBURY STREET, 6TH FLOOR
BOSTON, MA 02116
617-694-6678 | 617-224-4674(*f*)
www.drnuma.com

PATIENT INFORMATION:

NAME: DATE OF BIRTH:

ADDRESS:
STREET CITY/TOWN STATE & ZIP CODE

HOME PHONE: EMAIL:

MOBILE PHONE:

SEX: RACE: LANGUAGE: MARITAL STATUS:

SOCIAL SECURITY NUMBER:

PRIMARY CARE PHYSICIAN: PHONE:

REFERRING PHYSICIAN/FRIEND/FAMILY: PHONE:

HOW DID YOU HEAR ABOUT US?

IN CASE OF EMERGENCY

RESPONSIBLE PARTY:

RELATIONSHIP: PHONE:

PRIMARY INSURANCE

POLICY HOLDER'S NAME: RELATIONSHIP:

POLICY NUMBER: CO-PAY:

INSURANCE COMPANY NAME: PHONE:

SECONDARY INSURANCE

POLICY HOLDER'S NAME: RELATIONSHIP:

POLICY NUMBER: CO-PAY:

INSURANCE COMPANY NAME: PHONE:

CLAIM INFORMATION (*if applicable*):

[ ] WORKER'S COMPENSATION [ ] MOTOR VEHICLE [ ] PERSONAL INJURY

CONSENT INFORMATION

[ ] *NOTICE OF HEALTH PRIVACY PRACTICES (HIPPA)*: I ACKNOWLEDGE THAT I HAVE REVIEWED AND UNDERSTAND Dr. Numa's/Beacon Facial Plastic Surgery, LLC's Notice of Health Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by BFPS, LLC and my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

[ ] *MEDICAL PHOTOGRAPHY*: MEDICAL PHOTOGRAPHY IS ESSENTIAL FOR LEGAL DOCUMENTATION of your preoperative condition and planning of cosmetic surgery, as well as for the purpose of advancing medical education. I consent to the photography of appropriate portions of my face in preparation for surgery and for postoperative follow up. I grant BFPS, LLC the ongoing and unrestricted right to use my images for general information, education, scientific, medical, and public relations purposes.

[ ] *ASSIGNMENT OF INSURANCE BENEFITS:* I HEREBY AUTHORIZE PAYMENT to Dr. Numa/Beacon Facial Plastic Surgery, LLC of the insurance benefits otherwise payable to me, not exceeding the balance due to the regular charges for this procedure. I am financially responsible to BFPS,LLC for charges not covered by this authorization. Furthermore, I authorize the release of medical information necessary to process claims for medical benefits and authorize payment of medical benefits to Dr. Numa/BFPS, LLC.

AUTHORIZATION AND/OR CONSENT AS OUTLINE ABOVE IS HEREBY GRANTED. By selecting each notice of consent above, I hold the physician, it's agents, and employees harmless for any claim or injury or compensation resulting from activities authorized by this agreement.

PATIENT SIGNATURE:_____ **DATE:** _____

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Name: _____
DOB: _____
Age: _____

MEDICAL HISTORY QUESTIONNAIRE:

We welcome the opportunity to participate in your medical care. To ensure maximum safety and efficiency, we ask you provide accurate answers to the questions asked regarding you general sate of health. All the information will be held confidential as part of your medical records. ***Please answer every question. Do not leave a question blank.*** Thank you.

CHIEF CONCERN: _____

PAST MEDICAL HISTORY (*Medical Conditions***):**	
1	**5**
2	**6**
3	**7**
4	**8**

PAST SURGICAL HISTORY (*Previous Surgeries***):**	
1	**4**
2	**5**
3	**6**

MEDICATIONS & SUPPLEMENTS *Please be sure to include all prescribed and non-prescribed medications currently being taken, as well as, any dietary supplements. Specifically if you are currently taking any blood thinners, such as: Aspirin, Coumadin, NSAID, Garlic, Vitamin E, Fish Oil, Flaxseed Oil, Glucosamine, CoEnzyme Q-10.*	
1	**5**
2	**6**
3	**7**
4	**8**

ALLERGIES *Please include all allergies to medications and/or anesthesia. Also include if there is a family history of unusual reactions or allergies to anesthesia.*
1
2
3
4
5

SOCIAL HISTORY:		
1. DO YOU DRINK ALCOHOL?	**YES / NO**	
2. DO YOU USE ANY TOBACCO PRODUCTS?	**YES / NO**	
3. DID YOU EVER SMOKE?		
IF YOU DID, PLEASE LIST AGE, DURATION, AND FREQUENCY:		
4. DO YOU CURRENTLY USE ANY OTHER DRUGS RECREATIONALLY?		
IF YOU DO, PLEASE LIST NAME AND FREQUENCY:		
5. DO YOU EXERCISE?	**YES / NO**	IF YOU DO SO, PLEASE STATE HOW FREQUENTLY:

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Name: _____
DOB: _____
Age: _____

MEDICAL HISTORY QUESTIONNAIRE:

Please select all that apply.

[ ] VISUAL LOSS (ONE OR BOTH EYES)	[ ] DIFFICULTY BREATHING
[ ] "DRY" EYES	[ ] PREVIOUS INJURY TO NOSE
[ ] ITCHING OR IRRITATION OF EYES	[ ] NASAL ALLERGIES
[ ] BLURRED OR DOUBLE VISION	[ ] NOSE BLEEDS
[ ] CROSSED OR LAZY EYE(S)	[ ] SINUS CONDITIONS
[ ] CORNEA PROBLEMS	[ ] PREVIOUS NASAL OR SINUS SURGERIES
[ ] THYROID EYE DISEASE	IF YES, PLEASE LIST:
[ ] WEAR CONTACTS AND/OR GLASSES	
[ ] PREVIOUS EYE OR EYELID SURGERY	[ ] ANY BLEEDING DISORDERS?
IF YES, PLEASE LIST:	IF YES, PLEASE LIST:
	[ ] HEART MURMER
[ ] HAS THERE BEEN A RECENT CRISIS IN YOUR LIFE?	[ ] IRREGULAR HEARTBEAT
[ ] HAVE YOU EVER RECEIVED PSYCHIATRIC TREATMENT?	[ ] HYPERTENSION
[ ] HAVE YOU EVER BEEN HOSPITALIZED AS A RESULT OF SUCH TREATMENT?	[ ] CORONARY DISEASE OR HEART ATTACK
[ ] HAVE YOU EVER BEEN TREATED FOR ALCOHOL AND/OR SUBSTANCE DEPENDENCE?	[ ] STROKE

COSMETIC QUESTIONNAIRE:

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

WHEN LOOKING IN THE MIRROR, I BELIEVE I LOOK YOUNGER, THE SAME AS, OR OLDER THAN MY TRUE AGE.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

WHEN LOOKING IN THE MIRROR, I AM NOT CONCERNED, SOMEWHAT CONCERNED, VERY CONCERNED ABOUT THE APPEARANCE OF WRINKLES.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

Please select any and all cosmetic concerns that apply.

[ ] DARK CIRCLES	[ ] EXCESSIVE OR UNWANTED HAIR	[ ] FINE LINES/WRINKLES
[ ] PUFFY EYES	[ ] FROWN LINES	[ ] TIRED APPEARANCE
[ ] BLOTCHINESS/DISCOLORED SKIN	[ ] "11" BETWEEN EYEBROWS	[ ] JOWELS (SAGGING JAW LINE)
[ ] DARK SPOTS	[ ] WRINKLES NEAR LIPS	[ ] HEAVY EYELIDS
[ ] REDNESS	[ ] DEEP LINES AT CORNERS OF MOUTH	[ ] SHAPE OR SIZE OF NOSE
[ ] OILINESS	[ ] CROWS FEET	[ ] EARLOBES (TORN/SAGGING)
[ ] DRYNESS OR ROUGH PATCHES	[ ] VOLUME LOSS IN FACE	[ ] SHAPE OR SIZE OF EARS
[ ] VASCULAR OR PIGMENTED LESION ON FACE OR BODY		

HIPPA Notice of Privacy Practices

Beacon Facial Plastic Surgery, LLC

This notice explains how your medical information about you can be used and disclosed and how you can access it.

This Notice of Privacy Practices describes how we may use and disclose your health record or protected health information (PHI) for treatment, payment, and health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. Protected Health Information is information about you including demographics that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. The doctors and staff of Beacon Facial Plastic Surgery, LLC are committed to maintaining the privacy of your health information.

Uses and Disclosures of PHI

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your health care and treatment to provide health care services, pay your medical bills, support our office practice operation, and any other use required by law. We are required to abide by the terms of the notice currently in effect.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This can include communication with a third party, for example, to a referring physician, an emergency room doctor, or a home health agency that will be providing home services.

Payment: We will use your PHI as needed to obtain payment for health care services we have delivered. For example, we must provide a diagnosis to your health insurance company for proper billing for an office or hospital visit.

Health Care Operations: We may use or disclose, as needed, your PHI to support our business activities. These may include but are not limited to quality assessments, employee reviews, training of staff and medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical students who see you when you are in the hospital. In addition, we may have you sign in when you register at our front desk. We may call your name when we are ready to bring you to an exam room. We may disclose your PHI when reminding you of an appointment.

Disclosures without Authorization: Your PHI may be used or disclosed without your authorization in the following situations: Required by law; Public Health issues as required by law; Communicable Diseases; Health Oversight, Abuse or Neglect; Food and Drug Administration requirements; Legal proceedings; Law Enforcement; Coroners; Funeral Directors; Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Correctional Institutions; Required Uses and Disclosures. Under law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extent that your provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.Your heath record is the physical property of Beacon Facial Plastic Surgery, LLC The information in the record is accessible to you.

Your Rights

Following is a statement of your rights with regard to your protected health information (PHI)

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in a civil, criminal or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means that you may ask us to not use or disclose any part of your PHI for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you request. If the provider believes that it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use a different Healthcare Professional.

You have the right to request receipt of confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively.

You may request to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or to withdraw from the practice as provided in this notice.

Complaints. If you have any questions or would like additional information, you may contact our office manager, Ashley Penney at 617-694-6678. You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice becomes effective on or before July 11, 2009.