EYE & FACIAL
PLASTIC SPECIALISTS
Dr. Donald Hollsten & Dr. Jordan Hollsten

New Patient Information

Last Name _____ **First Name** _____ **MI** _____

(circle one) Dr. Mr. Mrs. Ms. Other **(circle one)** Jr. Sr. Other **Nickname** _____

Street Address _____ **Suite/Apt.** _____

City _____ **State** _____ **Zip** _____

Email _____

Home Phone _____

Cell Phone _____

Date of Birth _____ **Ethnicity** _____

Marital Status (circle one) Single Married Divorced Widowed Partner **Sex** M F N.B.

Primary Care Physician _____ **Cardiologist** _____

PHARMACY _____

Emergency Contact _____ **Emergency Phone** _____

REFERRAL SOURCE
How did you find our office?

- ❑ Physician _____
- ❑ Friend or Family Member _____
- ❑ Magazine Article or Advertisement _____
- ❑ Website _____
- ❑ Social Media
- ❑ Google

SIGNATURE _____ **DATE** _____

PATIENT MEDICAL HISTORY *(check all that apply)*(*Check all that apply)*

Skin

- ❑ Acne / History of Acne
- ❑ Excessive Dryness
- ❑ History of Keloid Scarring
- ❑ History of Eczema
- ❑ Collagen Disorders
- ❑ Current Open Sores
- ❑ Polycystic Ovary Syndrome
- ❑ History of Herpes (facial)
- ❑ History of skin cancers or pre-cancer
- ❑ History of Hyperpigmentation
- ❑ Other _____

Systemic

- ❑ Endocrine Disorders
- ❑ Hormonal Disorders
- ❑ Diabetes
- ❑ Swollen Joints
- ❑ Lupus/Scleroderma
- ❑ Bleeding Disorders
- ❑ Other _____

Psychiatric

- ❑ Depression
- ❑ Anxiety
- ❑ Other _____

Neurological

- ❑ Numbness
- ❑ Weakness
- ❑ Headaches
- ❑ Paralysis
- ❑ Other _____

Heart

- ❑ Irregular Heartbeat
- ❑ Heart Attack
- ❑ Pacemaker
- ❑ Coronary Artery Disease
- ❑ Other _____

Miscellaneous

- ❑ Cancer _____
- ❑ Immune System Disorder
- ❑ AIDS / HIV
- ❑ Stroke
- ❑ Dental implants
- ❑ _____

Medications

- ❑ Doxycycline / Tetracycline
- ❑ Isotretinoin
- ❑ St. John's Wort
- ❑ Immunosuppressive Medications

****Please Provide the front desk with a Full List of Medications or Write List on Back of This Page****

SURGICAL HISTORY

Procedure _____ Date_____

Procedure _____ Date_____

Procedure _____ Date_____

Procedure _____ Date_____

*List additional Procedures on the back of this page

FOOD / MEDICAL ALLERGIES Yes No _____

DO YOU TAN REGULARLY Yes No **Date of Last Tanning Session** _____

SMOKING HISTORY Never Current Former

ALCOHOL USE **Number of Drinks Per Day** _____ **Number of Drinks Per Week** _____

ARE YOU PREGNANT or TRYING TO GET PREGNANT Yes No not sure

FAMILY MEDICAL HISTORY (*Check all that apply)*

☐ Diabetes	Family Member _____
☐ High Blood Pressure	Family Member_____
☐ Cancer	Family Member _____
☐ Stroke	Family Member _____
☐ Bleeding Disorder	Family Member _____
☐ Immune System Disorder	Family Member _____
☐ Other _____	Family Member _____

YOUR SKINCARE ROUTINE:

MOISTURIZER	_____	AM	PM	OTHER
CLEANSER	_____	AM	PM	OTHER
SPF	_____	AM	PM	OTHER
EXFOLIANT	_____	AM	PM	OTHER
OTHER	_____	AM	PM	OTHER
	_____	AM	PM	OTHER

SIGNATURE _____ **DATE** _____

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PLASTIC SPECIALISTS
Dr. Donald Hollsten & Dr. Jordan Hollsten

PHOTOGRAPH CONSENT AND RELEASE

PATIENT NAME _____ **DATE** _____

MEDICAL RECORDS (please initial)

_____ I hereby acknowledge and understand that photographs will be taken of my face and parts of my face before and after surgery. I understand that these photographs will only be used for documentation in my medical record unless otherwise permitted. *See "Other Permissions."*

OTHER PERMISSIONS (please initial by the options to which you consent)

_____ **PHOTOGRAPHS**
I hereby give my consent for Donald A. Hollsten, M.D. and Jordan Hollsten, M.D. to use selected photographs on their website and professional social media platforms with basic details of my medical/surgical procedure to inform the public about specific plastic surgery methods and results. I understand that these photographs will be cropped and limited to specific parts of my face in order to protect patient confidentiality.

_____ Please initial here if you will allow our office to use the full image of your face without cropping.

_____ **VIDEOS**
I hereby give my consent for Donald A. Hollsten, M.D. and Jordan Hollsten, M.D. to use video documenting my medical procedure on their website and professional social media platforms with basic details of the procedure to inform the public about specific plastic surgery methods and results.

_____ **TESTIMONIALS**
I hereby give my consent for Donald A. Hollsten, M.D. and Jordan Hollsten, M.D. to use my personal written testimonial on their website and professional social media platforms. I understand that my testimonial will be quoted, followed by my first name and last initial and may include a brief descriptor of my medical/surgical procedure in order to provide better context.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

SIGNATURE _____ **DATE** _____

Ophthalmic Plastic and Reconstructive Surgery
4114 Pond Hill Road • Suite 100 • San Antonio, Texas 78231
T: (210) 616-0739 • F: (210) 616-0972
eyefacialplasticspecialists.com

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PLASTIC SPECIALISTS
Dr. Donald Hollsten & Dr. Jordan Hollsten

NOTICE OF PRIVACY PRACTICES

This practice uses and discloses health information about you for treatment, for payment of treatment, for administrative purposes, and for evaluation of quality of care you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact our privacy officer **Morgan Bowlin**.

OUR OBLIGATIONS We are required by law to: Maintain the privacy of protected health information, 2) Give you this notice of our legal duties and privacy practices regarding health information about you, 3) Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION You may revoke such permission at any time by writing your request to our practice Privacy Officer. ***For Treatment.*** We may use and disclose Health Information for your treatment and to provide you with treatment-related healthcare services. ***For Payment.*** We may use and disclose Health Information so that we, or others may bill and receive payment from you, and insurance company, or a third party for the treatment and services you received. ***For Health Care Operations***. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. ***Appointment Reminders, Treatment Alternatives, Health Related Benefits and Services, Individuals Involved in Your Care or Payment for Your Care.*** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort. ***Research.*** Before we use or disclose Health Information for research, the project will go through a special approval process.

SPECIAL SITUATIONS*_As Required by Law.* We will disclose Health Information when required to do so by international, federal, state or local law. ***To Avert a Serious Threat to Health or Safety***. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat. ***Business Associates.*** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. ***Organ and Tissue Donation.*** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement. ***Military and Veterans.*** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military. ***Workers' Compensation.*** We may release Health Information for workers' compensation or similar programs. ***Public Health Risks.*** We may disclose Health Information for public health activities. These activities include but are not limited to disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. ***Health Oversight Activities.*** We may disclose Health Information to a health oversight agency for activities authorized by law including audits, investigations, inspections, and licensure. ***Data Breach Notification Purposes.*** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information. ***Lawsuits, Disputes and Law Enforcement.*** We may release Health Information if the information is: (1) in response to a court order, subpoena, warrant,
summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime. ***Coroners Medical Examiners and Funeral Directors.*** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties. ***National Security and Intelligence Activities,***

Protective Services for the President and Others. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. ***Inmates or Individuals in Custody.*** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official.

USES AND DISCLOSURES THAT YOU CAN OBJECT AND OPT ***Individuals Involved in Your Care or Payment for Your Care.*** Unless you object, we may disclose your Protected Health Information to any person you identify. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. ***Disaster Relief***. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES The following uses and disclosures of your Protected Health Information will be made only with your written authorization: (1) Uses and disclosures of Protected Health Information, (2) Disclosures that constitute a sale of your Protected Health Information.

YOUR RIGHTS You have the following rights regarding Health Information we have about you by requesting the information in writing to our ***Privacy Officer***; Right to Inspect and Copy and Right to an Electronic Copy of Electronic Medical Records; Right to Get Notice of a Breach; Right to Amend; Right to Request Restrictions; Out of Pocket Payments; Right to Request Confidential Communications; Right to a Paper Copy of This Notice.

CHANGES TO THIS NOTICE We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Service. All complaints must be made in writing. **You will not be penalized for filing a complaint.** Contact information: Attn: Privacy Officer, 4114 Pond Hill Rd, Suite 100, San Antonio, TX 78231.

This Notice is effective on the date below. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

PRINTED NAME _____ **DATE** _____

SIGNATURE _____