The Maloney Center for Facial Plastic Surgery
6111 Peachtree Dunwoody Rd., Bldg E Suite 201, Atlanta, GA 30328
Phone: 770-804-0007 Fax: 770-804-0777

DATE_____

FULL NAME _____ SEX _____ AGE _____

BIRTHDATE _____ SOCIAL SECURITY # _____

ADDRESS_____ CITY_____

STATE _____ ZIPCODE _____ EMAIL ADDRESS _____

Marital Status _____ Home Phone #_____ Mobile/Cell # _____

Employer _____ Occupation _____ Work # _____

Address_____City_____State_____ZipCode_____

Spouse's Name _____Spouse's Employer _____Occupation_____

Closest local relative or friend not living with you_____

Address _____Phone #_____

Children's names and ages_____

Any family member treated here before? _____ If yes, name/relationship / approximate date _____

If the PATIENT is a MINOR, please complete this section:

Father's Name _____Employer _____ Phone#_____

Mother's Name _____ Employer _____Phone# _____

Person Responsible For Bill, (if other than patient)

Name _____Relationship to Patient _____ Phone#_____

Address_____ City_____ State_____ Zip Code_____

REFERRAL SOURCE

Physician (Specify) _____
Friend (Specify) _____
TV/ Network _____
Website (Specify) Google____ Maloney Center ____ RealSelf ____Other_____
Skin Care (Specify) _____
Magazine (Specify) _____
Seminar _____
Other_____

OUT OF STATE AND INTERNATIONAL PATIENTS,
PLEASE LET US KNOW IF WE CAN ASSIST WITH YOUR TRAVEL PLANS

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PERSONAL HISTORY

NAME: _____

Please list any medical problems or previous hospitalizations_____
_____

Have you had any serious past illnesses?_____

Please list any accidents or injuries_____

Please list any past surgeries (including minor surgery or surgery as a child)_____
_____

YES NO

___ ___ Do you have any allergies to medication? List medications _____
_____
___ ___ Do you have any food, environmental, or latex allergies? List reactions_____
_____
___ ___ Are you currently taking any drug or medications? How often? List (Include over the counter)_____
____ ___ Do you take vitamins or herbal products? List_____
____ ___ Do you drink more than 6 cups of coffee per day?
____ ___ Do you drink alcohol? How much? How often?_____
____ ___ Do you smoke? How much per day?_____
____ ___ Do you ever get cold sores or fever blisters?_____
____ ___ Do you have skin sensitivities, frequent rashes, or eczema?
____ ___ Have you ever taken Accutane?
____ ___ Do you have a skincare regimen you follow? Describe_____
_____
____ ___ Have you ever received local anesthesia? (Novacaine)
____ ___ Did you have a reaction to anesthesia?
____ ___ Are you a past/present carrier of a contagious disease? Please specify_____
_____
____ ___ Are you or could you be pregnant?
____ ___ Have you taken medicine such as Cortisone or steroid during the past year?
____ ___ Do you have a personal or family history of any bleeding or clotting abnormalities?
____ ___ Do you bleed for more than a half hour after a needle stick?
____ ___ Do you bleed a day or more after surgery or a tooth extraction?
____ ___ Do you bruise easily?
____ ___ Do you bruise without cause?
____ ___ Do you bruise larger than a half dollar?
____ ___ Do you bruise from injections?

DATE OF YOUR LAST PHYSICAL?_____DATE OF MOST RECENT BLOODWORK_____DATE OF YOUR LAST CHEST X-RAY_____HAVE YOU HAD AN ABNORMAL CHEST X-RAY?_____DATE OF LAST EKG_____HAVE YOU HAD AN ABNORMAL EKG_____

PRIMARY CARE PHYSICIAN_____PHONE#_____

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NAME:_____

DO YOU HAVE OR HAVE YOU EVER HAD:

YES	NO		YES	NO	
_____	_____	Heart disease or heart trouble	____	____	Mitral valve prolapse
_____	_____	High blood pressure	____	____	Diabetes
_____	_____	Lung disease	____	____	Muscle weakness
_____	_____	Hay fever	____	____	Difficulty urinating
_____	_____	Kidney disease	____	____	Jaundice
_____	_____	Liver disease	____	____	Headache or dizzy spells
_____	_____	Epilepsy/seizures/neurological problems	____	____	Bowel/colon disease or problems
_____	_____	Thyroid or goiter problems	_____	____	Shortness of breath
_____	_____	Chest pain	_____	____	Back or neck trouble
_____	_____	Chronic cough	_____	____	Ulcers/stomach trouble
_____	_____	Recent respiratory infection	_____	____	Do you use eye drops?
_____	_____	Skin trouble/infections/rashes/irritations	_____	____	Treatment of genital area
_____	_____	Keloid or ugly scars	_____	____	Are you easily depressed
_____	_____	Glaucoma	_____	____	Hiatal hernia
_____	_____	Phlebitis	_____	____	Blood transfusion
_____	_____	Problems lying flat	_____	_____	Ankle swelling
_____	_____	Nosebleeds	_____	_____	Facial fractures
_____	_____	Fainting	_____	_____	Anemia
_____	_____	Asthma	_____	_____	Drug or alcohol dependency
_____	_____	Have you considered seeing a psychologist/ therapist	_____		Height
_____	_____	Are you seeing a therapist now?			
_____	_____	Are you on a special diet?	_____		Weight
_____	_____	Recent weight loss (amount)_____			
_____	_____	Any exposure to a communicable disease in the last 3 weeks? Explain_____ _____			

DO YOU HAVE ANY OF THE FOLLOWING: Dentures_____Partial plate_____Bridgework_____

ARE YOU WEARING ANY OF THE FOLLOWING: Contacts___False eyelashes___Hearing aid____
Wig/hairpece_____ Permanent eyeliner or other
Permanent cosmetics _____

FAMILY HISTORY: Diabetes____Bleeding____Heart disease____Anesthesia problems_____
Other_____

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR HEALTH?_____

Signed_____
(Patient or Guardian)

THE REQUESTED PERSONAL INFORMATION IS A NECESSARY PART OF OUR EVALUATION. ALL INFORMATION GIVEN TO US IS CONFIDENTIAL.

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AUTHORIZATION FOR EXAMINATION

Name:_____

Date of Birth:_____

I, _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery/ treatment. I authorize the taking of photographs at the direction of my physician and under such conditions as may be approved by him.

SIGNATURE:_____DATE:_____

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN

WITNESS:_____

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NON-INSURANCE ACKNOWLEDGEMENT

Name:_____

Date of Birth:_____

I understand and accept that The Maloney Center for Facial Plastic Surgery reserves the right to not participate in any insurance filings, related to any procedures and/ or surgeries performed by Dr. Brian Maloney. A copy of this acknowledgement shall be considered as valid as the original.

I understand I am responsible for professional services rendered as outlined in the financial policy.

SIGNATURE:_____DATE:_____

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN

WITNESS:_____DATE:_____

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CONSENT TO RECEIVE TEXTS AND/OR EMAILS

Name:_____

Date of Birth:_____

To provide you with the safest and most up to date services we have created a document that protects you, the patient. With the increased use of text messaging for appointment reminders we want to make sure you are aware that you will be texted appointment reminders. You have the option at any time to OPT out of this service.

"Federal law prohibits this practice from sending you texts or email which are unencrypted or "unsecure"." However, many of our patients find it convenient to communicate with our office by traditional text and/or email. Those modes of communication are generally not considered "secure". Some of our patients appreciate the tradeoff between ease of use/ convenience and security. We want to accommodate your preferences. If you would like to communicate with us by "unsecure" text or email, please confirm below by providing your authorization. We will keep your preferences in force with no current expiration date until we learn otherwise. You can change your mind at any point down the road. With our texting service you have the option at any time to OPT out of receiving text messages. If messages are sent through such channels, they may no longer be protected by HIPAA. Finally, whether or not you decide to use email or text messaging, your choice will have no impact on our decision to treat you.

I authorize the practice to communicate with me by "unsecure" text; that text number being:

_____ number

_____ signature/date

I authorize the practice to communicate with me by "unsecure" email, that email address being:

_____ email address

_____ signature/ date

MALONEY CENTER
FOR FACIAL PLASTIC SURGERY

Consent to Receive Text Messages

By providing my mobile telephone number below and signing this form, I expressly consent to receive text messages (SMS/MMS) from Maloney Center for Facial Plastic Surgery regarding:

- Special promotions and exclusive offers
- New products and services
- Educational information
- Practice news and events
- Appointment reminders and other patient communications

I understand that: My consent to receive marketing text messages is voluntary and is **not** a condition of receiving medical treatment or purchasing any products or services.

- Message frequency may vary.
- Message and data rates may apply depending on my wireless carrier and plan.
- I may opt out of marketing text messages at any time by replying **STOP** to any marketing text message.
- I may request assistance by replying **HELP** or by contacting the office directly.
- I understand that opting out of marketing messages will not prevent me from receiving text messages that are necessary for my care, such as appointment reminders, scheduling updates, or other healthcare-related communications, unless I specifically request otherwise where permitted by law.

Mobile Phone Number: _____

☐ I agree to receive marketing and promotional text messages from Maloney Center for Facial Plastic Surgery.

☐ I do not wish to receive marketing or promotional text messages.

Patient Name: _____

Patient Signature: _____Date: _____

By checking "I agree," I confirm that I am the authorized user of the mobile number provided and consent to receive recurring automated promotional text messages from Maloney Center for Facial Plastic Surgery.