Patient Registration

Patient: _____ Today's Date: _____
Last Name First Name Middle Initial Preferred Name

Address: _____ # Home: _____

City: _____ State: _____ Zip: _____ # Work: _____

Email: _____ # Mobile: _____

Birth date: _____ Age: _____ Sex: [ ] male [ ] female

Would you like to hear about new products and promotions? [ ] yes [ ] no
May we contact you to remind you about upcoming appointments? [ ] yes [ ] no

Patient's Employer: _____ Patient's Occupation: _____

Marital Status: [ ] single [ ] married [ ] widowed [ ] separated [ ] divorced

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

ID #: _____ ID #: _____

Group #: _____ Group #: _____

***WE ARE IN-NETWORK WITH THE FOLLOWING INSURANCE PLANS: BLUE CROSS BLUE SHIELD, PREMERA, MEDICARE, AETNA, CIGNA (LIFEWISE), HMA & REGENCE. DEPENDING ON YOUR INSURANCE PLAN AND POLICY YOU MAY HAVE FULL, LIMITED, OR NO COVERAGE WITH OUT-OF-NETWORK PROVIDERS. _____(initial)**

Emergency Information and Release

In case of an emergency, local friend or relative to be notified (not living at same address if possible):

Name: _____ Relationship to Patient: _____

Mobile Phone: ( )_____ Work Phone: ( )_____

Assignment and Release: I hereby authorize my insurance and government benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim.

Signature: _____

How Did You Hear About Us?

[ ] A friend or family member (name) _____ may we contact? [ ] yes [ ] no

[ ] Seattle Magazine Top Doctors / Best Cosmetic Surgeon Readers' Choice Award

[ ] Best of 425 Magazine – Best Cosmetic Surgeon and Best Place for Skincare Award

[ ] Social Media (please specify) _____

[ ] An article or television / radio appearance in _____

[ ] Newsletter or mailer

[ ] Auction or charitable event (please specify) _____

[ ] My physician (full name) _____

[ ] Other (please specify) _____

If you have any specific **interests**, please check all that may apply:

Facial Cosmetic Surgery

- ❑ Rhinoplasty
- ❑ Face & Neck Lift
- ❑ Eye Lid Lift
- ❑ Brow & Forehead Lift
- ❑ Cheek & Midface Lift
- ❑ Laser Resurfacing
- ❑ Fractional Laser Resurfacing
- ❑ Chin Augmentation
- ❑ Cheek Augmentation
- ❑ Neck Liposuction
- ❑ Lip Augmentation
- ❑ Lip Lift
- ❑ Buccal Fat Removal
- ❑ Otoplasty
- ❑ Fat Injections
- ❑ Feather Lift

Body Cosmetic Surgery

- ❑ Breast Augmentation
- ❑ Breast Lift
- ❑ Breast Reduction
- ❑ Buttock Lift
- ❑ Liposuction
- ❑ Abdominoplasty
- ❑ Arm Lift
- ❑ Full Body Lift
- ❑ Body Contouring
- ❑ Fat Injection to Breast
- ❑ Fat Injection to Body
- ❑ Hand Rejuvenation

Reconstructive Surgery

- ❑ Septoplasty
- ❑ Skin cancer
- ❑ Facial trauma
- ❑ Ptosis surgery
- ❑ Eyelid reconstruction
- ❑ Tearing problems
- ❑ Hand Surgery

Injectables

- ❑ Botox & Dysport
- ❑ Restylane
- ❑ Juvederm
- ❑ Radiesse
- ❑ Perlane
- ❑ Sculptra
- ❑ ArteFill
- ❑ Fat Injections
- ❑ Sclerotherapy

Laser Treatments

- ❑ Thermage for Face
- ❑ Thermage for Body
- ❑ Thermage for Cellulite
- ❑ CoolSculpting Cryolipolysis
- ❑ Non-invasive fat removal
- ❑ Fotofacial
- ❑ Intensive Fotofacial
- ❑ Facial Vein Removal
- ❑ Leg Vein Removal
- ❑ Freckles & Brown Spots
- ❑ Laser Hair Removal
- ❑ Polaris

Dermatology

- ❑ Skin cancer screening
- ❑ Mole checks
- ❑ Biopsies
- ❑ Skin aging
- ❑ Acne
- ❑ Acne scars
- ❑ Rosacea
- ❑ Biopsy-proven skin cancer
- ❑ Suspected skin cancer
- ❑ Mole removal
- ❑ Cysts
- ❑ Lipoma
- ❑ Skin lacerations (cuts) and scars resulting from prior injury
- ❑ Rashes
- ❑ Eczema
- ❑ Warts
- ❑ Fungal infections
- ❑ Bacterial infections
- ❑ Hair loss/alopecia
- ❑ Pigmentation issues

Skin Care & Products

- ❑ Microdermabrasion
- ❑ Skin Care Analysis
- ❑ Chemical Peels
- ❑ ToneAbrasion
- ❑ Obagi products
- ❑ Latisse for eyelashes
- ❑ Skin Medica products
- ❑ SPF
- ❑ ScarFade

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

When looking at my face 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

Each day, I look at myself in the mirror:

Once or twice per day		**Every now and then to freshen up**		**More than 10 times per day**
1	2	3	4	5

I am looking for a procedure that can give me a:

Small improvement with minimal down-time		**Moderate improvement with some down-time**		**Significant improvement with longer down-time**
1	**2**	**3**	**4**	**5**

MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____

MEDICATIONS (including over the counter):

1. _____
2. _____
3. _____
4. _____
5. _____

Please attach a sheet if more space needed

DRUG ALLERGIES (indicate what happens)

1. _____
2. _____
3. _____
4. _____
5. _____

Please attach a sheet if more space needed

MEDICAL ILLNESSES

1. _____
2. _____
3. _____
4. _____
5. _____

Please attach a sheet if more space needed

PAST SURGICAL PROCEDURES (indicate date of procedure)

1. _____
2. _____
3. _____
4. _____
5. _____

Please attach a sheet if more space needed

FAMILY HISTORY (Please indicate **F**ather, **M**other, **G**randparent, **S**ibling)

_____Allergies/Asthma	_____Diabetes	_____Mental illness
_____Anesthesia reaction	_____Heart disease	_____Seizures/Epilepsy
_____Bleeding tendency	_____High blood pressure	_____Skin cancer
_____Cancer	_____Melanoma	_____Stroke

SOCIAL HISTORY

Occupation: _____ Hobbies: _____

Marital status (please circle): Single Married/Partner Separated Divorced Widowed

Do you smoke? Y N
Have you ever smoked? Y N
When did you quit? _____
How many years did you smoke? _____
How many packs/day average? _____

Do you drink alcoholic beverages? Y N
Average number of drinks/day: 1 2 3 4+
Are you at high risk for HIV/AIDS? Y N
Have you been HIV tested? Y N
HIV test results: Positive Negative

Are you pregnant or nursing? Y N
Were you hospitalized in the last 6 months? Y N
Are you under the care of a doctor? Y N
Have you ever been on Accutane for Acne? Y N
Have you ever had plastic surgery? Y N

SYSTEMIC REVIEW: Please circle **Y**es or **N**o if you have or you ever have had any of the following

SKIN

Abnormal pigmentation	Y N
Acne	Y N
Burns very easy	Y N
Hives, Eczema, Rash	Y N
Melasma (pregnancy mask)	Y N
Skin cancer/Melanoma	Y N
Tans very easy	Y N
Thick, raised, itchy scars	Y N
Cold sores	Y N

HEAD/EYE/EAR/NOSE/THROAT

Allergy/Hay fever/Itchy eyes & nose	Y N
Broken nose	Y N
Dizziness	Y N
Double vision/Blurry vision	Y N
Dry eyes requiring treatment	Y N
Facial weakness/Paralysis	Y N
Glaucoma	Y N
Impaired hearing	Y N
Nosebleeds	Y N
Sinus infections	Y N

NECK

Radiation treatment	Y N
Spine surgery	Y N
Surgical removal of tumor	Y N

RESPIRATORY

Asthma	Y N
Chronic cough	Y N
Difficulty breathing	Y N
Pneumonia	Y N
Pulmonary embolism	Y N
Sleep apnea	Y N
Tuberculosis	Y N

CARDIOVASCULAR

Angina/Chest pain	Y N
Angioplasty	Y N
Bypass surgery	Y N
Congestive heart failure	Y N
Heart attack	Y N
Heart murmur	Y N
Heart valve disease/artificial valve	Y N
High blood pressure	Y N
Irregular heart rhythm	Y N
Pacemaker or Defibrillator	Y N
Rheumatic fever	Y N
Shortness of breath with exercise	Y N
Stent placed in heart	Y N
Swelling of ankles	Y N

GASTROINTESTINAL

Anorexia	Y N
Difficulty swallowing	Y N
Frequent Constipation	Y N
Frequent Diarrhea	Y N
Hepatitis A, B, or C	Y N
Liver malfunction	Y N
Peptic ulcer	Y N
Reflux disease	Y N
Unexplained weight loss	Y N
Vomiting blood	Y N

GENITOURINARY

Blood in urine	Y N
Frequent urination	Y N
Kidney malfunction	Y N
Kidney stones	Y N
Painful urination	Y N

MUSCOLOSKELETAL

Arthritis	Y N
Artificial joints	Y N
Blood clots in legs	Y N
Broken bones	Y N
Poor circulation to legs	Y N
Ulcers on feet	Y N
Varicose veins	Y N

HEMATOLOGIC

Anemia	Y N
Easy bruising	Y N
Excessive bleeding	Y N
Hemophilia	Y N
Phlebitis	Y N

ENDOCRINE

Diabetes	Y N
Glucose intolerance	Y N
Thyroid disease	Y N

NEUROPSYCHIATRIC

Anxiety	Y N
Bipolar disorder	Y N
Body image problems	Y N
Convulsions	Y N
Depression	Y N
Obsessive-Compulsive disorder	Y N
Panic disorder	Y N
Stroke or Paralysis	Y N
Have you ever had psychiatric care?	Y N
Are you under current psychiatric care?	Y N

Please list any other medical conditions not listed above: _____

1503 2nd Avenue West
Seattle, Washington 98119
Phone: (206) 216-4500
Fax: (206) 216-4501

amadi aesthetics
PLASTIC SURGERY

HIPAA Acknowledgement and Informed Financial Consent Form

This consent form allows Amadi Aesthetics (AAPS) to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment, or health care operations. Amadi Aesthetics Plastic Surgery (AAPS) has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent. To the extent permitted by Washington State law, I authorize AAPS to use or disclose information about me for the following reasons:

Treatment: AAPS may disclose information about me to my primary care physician, referring physicians, and other individuals consulted by my physician so that those involved in my treatment can manage my healthcare needs. If applicable, I expressly consent to the use and disclosure of information regarding testing and/or treatment for substance abuse, mental health, sexually transmissible and genetic conditions to such consultants and/or other healthcare personnel that may be involved in my care.

Initials of Patient or Legal Representative: _____

Payment: AAPS may use and disclose information about me to any person or corporation which is or may be liable for all or any portion of the charges incurred in connection with these services, including insurance companies, health care service plans, workers' compensation carriers, adjusters or attorneys, to the extent necessary to obtain reimbursement.

Initials of Patient or Legal Representative: _____

Operations: AAPS may use and disclose information about me as needed to support its business activities. Examples of business activities may include notification of pharmaceutical and medical device recalls, communication about health-related products or services provided by AAPS, and quality improvement activities designed to assess and improve the quality and effectiveness of the healthcare and service AAPS provides to its patients.

Initials of Patient or Legal Representative: _____

Cosmetic Procedures

I, the undersigned agree as follows: (1) I authorize that my insurance benefit be paid directly to Amadi Aesthetics Plastic Surgery. (2) I am financially responsible for any balance due and for non-covered services. (3) I authorize the doctor or insurance company to release any information required for processing of any claims. (4) If an amount due must be sent for collection, I will be responsible for all collection costs, including attorney's fees, costs, and expenses. (5) The venue of this Agreement shall be King County, Washington in a court chosen by this office. I understand the purpose of this form and my questions were answered to my satisfaction.

x_____ Date: _____
(**Signature** of Patient / Guarantor / Guardian / Representative)

_____
(**Printed** Name of Patient / Guarantor / Guardian / Representative)

amadi aesthetics
PLASTIC SURGERY

At Amadi Aesthetics Plastic Surgery we *take pride in providing* our patients with *extraordinary care and outstanding results.* Before & After photos are important for our prospective patients to feel assured that they are in the best of hands. *We hope you can let us share your photos from your cosmetic journey here with us.* Please let us know what type of photos you will allow us to share with our prospective patients by filling out this form below.

Before & After Image Consent Form

Patient Name: _____ Date:_____

I consent for medical photographs to be taken of me by Dr. A.J. Amadi MD, FACS or a staff member of Amadi Aesthetics Plastic Surgery. I understand that the information may be used in my medical record, for purpose of medical teaching, for demonstration purposes including an office photo album, on our website for prospective patients, and/or on our practice's social media accounts for prospective patients. These photographs will be used without identifying information such as my name. By consenting to these medical photographs I acknowledge and agree that no compensation will be provided for the use of my images. Refusal to consent to photographs will in no way affect the medical care I will receive. If I wish to withdraw my consent in the future, I may do so at any time with a written request.

I authorize the use of my images for the uses listed below: (Please initial indicating YES or NO)

_____YES _____NO	My medical record and for medical teaching purposes
_____YES _____NO	In-office teaching and demonstration purposes (photo album etc.)
_____YES _____NO	Our website for prospective patients
_____YES _____NO	Amadi Aesthetics social media accounts for prospective patients
_____YES _____NO	Amadi Aesthetics *RealSelf* pages for prospective patients

(Optional) Other terms or conditions applied:

_____

By signing below I confirm that this form has been explained to me in terms which I understand and

I grant permission for the use of my photos for the purposes I have indicated above.

Patient Signature: _____ *Date:* _____

Provider or PCC Signature: _____ *Date:* _____