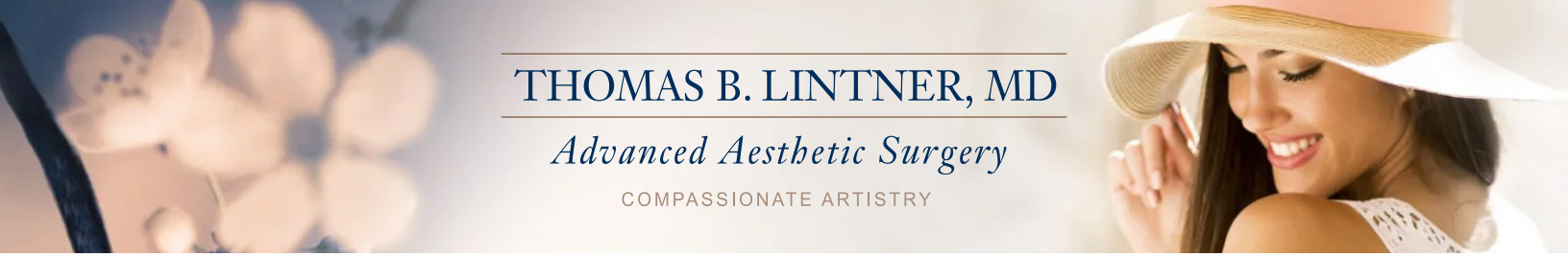


PATIENT INFORMATION | PATIENT DATABASE

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

SEX ☐ FEMALE SOCIAL SECURITY NO: _____

☐ MALE DATE OF BIRTH: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____ CELL PHONE: _____

DO YOU GIVE PERMISSION TO LEAVE MESSAGES AT ☐ HOME ☐ WORK ☐ CELL ☐ NONE

PERMISSION TO SEND EMAILS? ☐ YES ☐ NO EMAIL: _____

OCCUPATION: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

INFORMATION REGARDING SPOUSE OR GUARDIAN

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

OCCUPATION: _____

EMPLOYER: _____ WORK TELEPHONE: _____

EMPLOYER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

NAME OF PERSON WE SHOULD CONTACT IN CASE OF EMERGENCY: _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

WOULD YOU PLEASE TELL US WHO REFERRED YOU TO OUR OFFICE?: _____

INFORMATION IF THE PATIENT IS A MINOR

MOTHER'S NAME: _____

MOTHER'S HOME TELEPHONE: _____ WORK TELEPHONE: _____

FATHER'S NAME: _____

FATHER'S HOME TELEPHONE: _____ WORK TELEPHONE: _____

INSURANCE INFORMATION

NAME OF THE INSURED (IF OTHER THAN THE PATIENT):: _____

INSURANCE COMPANY NAME: _____ COMPANY TELEPHONE: _____

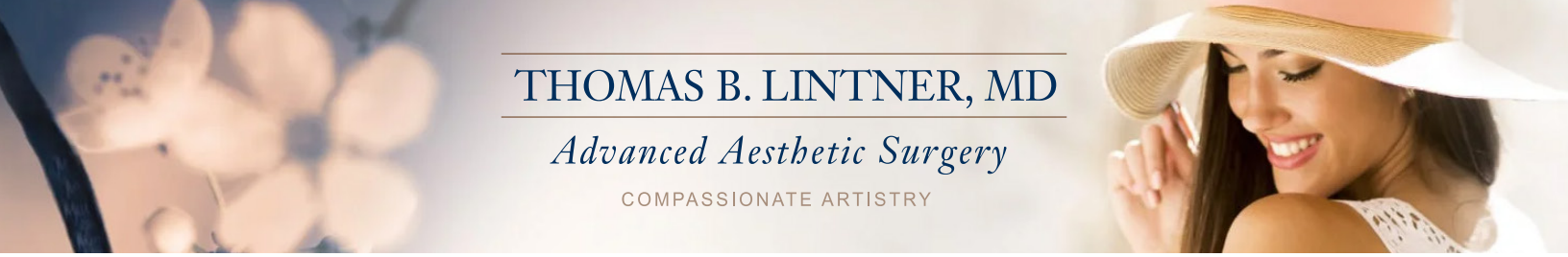
INSURED SOCIAL SECURITY NO.: _____ INSURED DATE OF BIRTH: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

COMPANY ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MEDICARE NUMBER: _____ MEDICAID NUMBER: _____



MEDICAL HISTORY

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

DATE OF BIRTH: _____ DATE OF LAST PHYSICAL EXAM : _____

FAMILY PHYSICIAN: _____

PHYSICIAN'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HEIGHT: _____ WEIGHT: _____

ALLERGIES: _____

NAME ANY MEDICATIONS OR ANYTHING THAT YOU ARE ALLERGIC TO AND HOW YOU REACTED TO THEM: _____

_____

_____

_____

DO YOU SMOKE: ☐ NO ☐ YES PACKS/DAY _____ ☐ STOPPED _____ ☐ YEARS/MONTHS AGO

HOW MUCH ALCOHOL PER DAY _____

MEDICATIONS: check any of the following medications you are presently talcing or have taken in the past year.

☐ Contraceptives
☐ Cortisone or Steroids
☐ Aspirin
☐ Anti-Inflammatories
☐ Arthritis Medicine
☐ Antibiotics
☐ Pain Medicine
☐ Hormones
☐ Blood Pressure Pills
☐ Heart Medicine
☐ Diuretic (Water Pills)
☐ Thyroid
☐ Asthma Medicine or Inhalers
☐ Sleeping Pills
☐ Tranquilizer or Nerve Pills
☐ Diet Pills
☐ Herbs
☐ Vitamins

LIST MEDICATIONS/DOSAGE/FREQUENCY YOU ARE PRESENTLY TAKING:: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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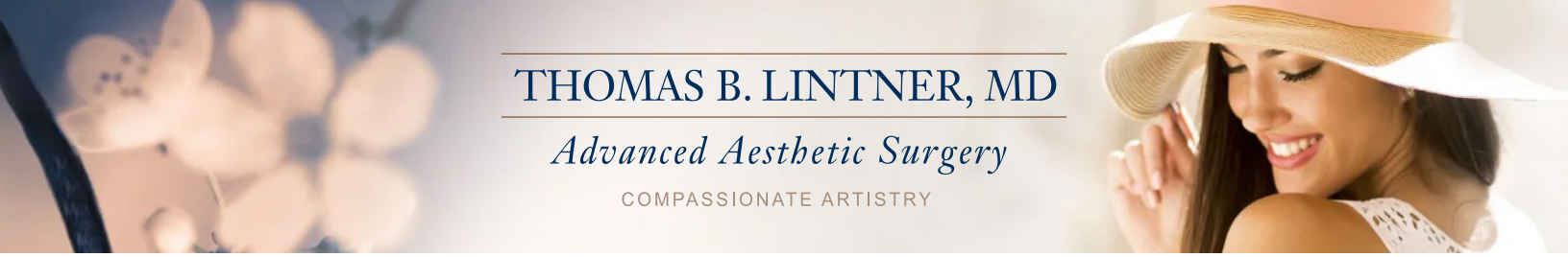
_____

_____



MEDICAL HISTORY

ILLNESSES: HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Blood Transfusions
- ☐ Ulcer
- ☐ Migraine
- ☐ Varicose Veins
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Kidney Stone
- ☐ Hernia
- ☐ Colitis
- ☐ Arthritis
- ☐ Back Trouble/Neck Trouble
- ☐ Asthma
- ☐ Convulsion
- ☐ Depression
- ☐ Anxiety
- ☐ Nervous Breakdown
- ☐ Jaundice
- ☐ Diabetes
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Cancer
- ☐ Skin Disease
- ☐ Reaction to Latex
- ☐ Reflux/Indigestion
- ☐ Sleep Apnea
- ☐ Reaction to Anesthesia

PLEASE LIST MAJOR ILLNESSES:

ILLNESS: _____ DATE: _____

ILLNESS: _____ DATE: _____

ILLNESS: _____ DATE: _____

PLEASE LIST PREVIOUS OPERATIONS AND DATES:

OPERATION: _____ DATE: _____

OPERATION: _____ DATE: _____

OPERATION: _____ DATE: _____

PLEASE LIST PREVIOUS OPERATIONS AND DATES:

INJURY: _____ DATE: _____

INJURY: _____ DATE: _____

HAVE ANY RELATIVES HAD (CIRCLE):

DIABETES HEART DISEASE HEART ATTACK BLEEDING DISORDER ASTHMA CANCER STROKE

HOW DID YOU LEARN ABOUT OUR OFFICE?

_____

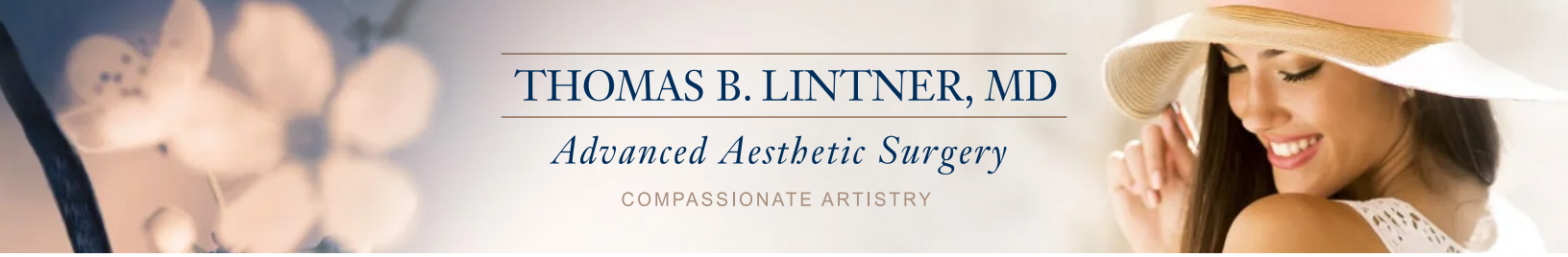
_____

_____

THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I HAVE NOT PURPOSEFULLY LEFT OUT PERTINENT INFORMATION OR GIVEN INACCURATE INFORMATION.

PATIENT OR PARENT'S SIGNATURE: _____ DATE: _____

THANK YOU FOR YOUR HONESTY. THIS CORRECT INFORMATION WILL HELP ME DELIVER SAFER MEDICAL AND SURGICAL CARE TO YOU.



AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Dr. Thomas B.Lintner (Advanced Aesthetic Surgery) to release information related to psychiatric care. drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I also authorize release of information to any hospital or physician to which I may be referred by this office.

Signature of person giving consent _____ Date: _____

Relationship to patient _____

Patient unable to sign due to _____

ASSIGNMENT OF BENEFITS

I hereby authorize assignment and payment directly to Dr. Thomas B. Lintner M.D. (Advanced Aesthetic Surgery) major medical benefits due me.

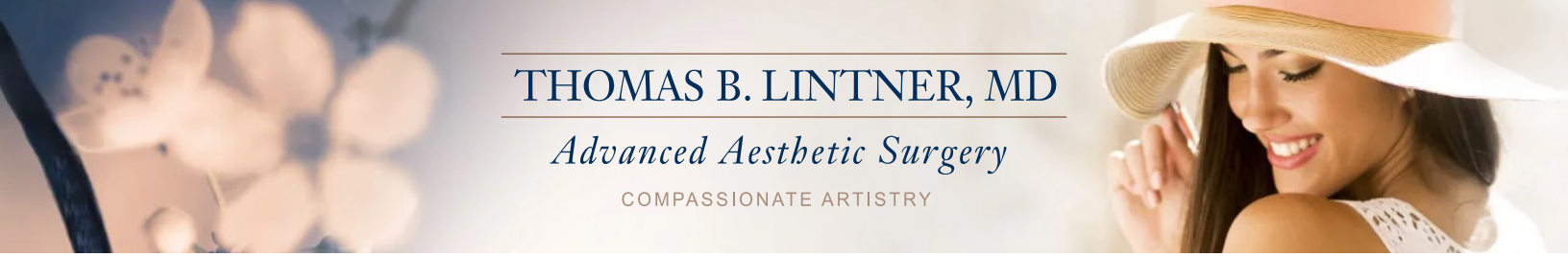
HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.

Signature _____ Date: _____

Relationship to patient _____

Patient unable to sign due to _____

We request fees for office services and visits at the time the service is rendered.



AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS AND/OR SLIDES

INSTRUCTIONS

This is a consent document that has been prepared to help inform you concerning permission to take photographs and/or slides and to use these images for a purpose as defined within this consent.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION

Medical photographs and/or slides may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photography and slides for a purpose.

I. CONSENT TO TAKE PHOTOGRAPHS/SLIDES:

I hearby authorize A.A.S. and associates or licensees to take pre-operative, intra-operative, and post operative photographs and/or slides.

Patient Signature: _____

II. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES:

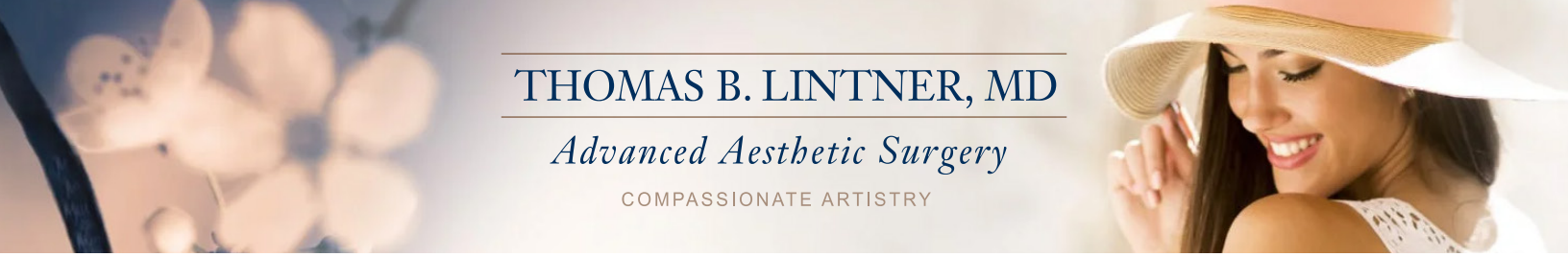
I hereby authorize A.AS. and associates or licensees to use pre-operative, intra-operative, and post-operative photographs, and/or slides for professional medical purposes deemed appropriate including but not limited to showing these images for purposes of medical education, patient education, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Patient Signature: _____

Date: _____

Witness: _____



PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY

I understand that as part of the provision of healthcare services, Advanced Aesthetic Surgery creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

THIS CONSENT IS GIVEN FREELY WITH THE UNDERSTANDING THAT:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treaiment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health lniormation which have been previously agreed upon.
4. It may become necessary to release your protected health information to financial parties, credit card entities, banks and finance companies, when requested to facilitate your payment. Services that are performed that are paid with credit card, debit card, or finance company are not eligible for payment challenges after services are provided. By signing this iorm, I am irrevocably consenting to allow Advanced Aesthetic Surgery to use and disclose my protected health information when requested to process an account or assist wlth payment

_____ _____

(PATIENT"S NAME: PRINTED) DATE

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY}

_____ _____

WITNESS (OPTIONAL) DATE