Marotta
FACIAL PLASTIC SURGERY

WWW. MAROTTAMD.COM
(631) 982-2022

WELCOME! PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:
PATIENT INFORMATION AS OF _____ (ENTER TODAY'S DATE)
(PRINT LEGIBLY & FILL IN ALL FIELDS)

PATIENT'S NAME _____
LAST FIRST MIDDLE

ADDRESS _____ NY
STREET & APT # CITY STATE ZIP

HOME PHONE _____ CELL PHONE _____ OTHER PHONE _____

ANY RESTRICTIONS FOR CONTACTING YOU? ☐ NO ☐ YES E-MAIL _____

CONTACT RESTRICTIONS: _____ DRIVERS LICENSE # (INCLUDE STATE) _____

AGE _____ BIRTHDATE _____ SS# _____ SEX ☐ FEMALE ☐ MALE

MARITAL STATUS: ☐ SINGLE ☐MARRIED TO: _____ ☐ OTHER: _____

PATIENT'S EMPLOYER _____ OCCUPATION _____

WORK PHONE _____ EXT: _____ IS IT OKAY TO CALL YOU AT WORK? ☐ YES ☐ NO

ADDRESS _____
STREET & SUITE # CITY STATE ZIP

EMERGENCY CONTACT _____ RELATIONSHIP TO PATIENT _____

HOME PHONE _____ WORK PHONE _____ OTHER PHONE _____

ADDRESS _____
STREET & APT # CITY STATE ZIP

PRIMARY HEALTH INSURANCE COMPANY _____

ID#: _____ GROUP # _____ INS. PHONE _____

REFERRAL REQUIRED? ☐ NO ☐ YES COPAY? ☐ NO ☐ YES $ _____

INSURED: NAME _____ DOB _____ EMPLOYER _____

SECONDARY HEALTH INSURANCE COMPANY _____

ID#: _____ GROUP # _____ INS. PHONE _____

REFERRAL REQUIRED? ☐ NO ☐ YES COPAY? ☐ NO ☐ YES $ _____

INSURED: NAME _____ DOB _____ EMPLOYER _____

HOW DID YOU HEAR ABOUT US?

NAME **PHONE**

☐ PHYSICIAN REFERRED _____
☐ FRIEND, RELATIVE, PATIENT _____
☐ SEMINAR OR LECTURE
☐OTHER WEBSITE _____

☐ OTHER (PLEASE EXPLAIN) _____ ☐ OUR WEBSITE

I UNDERSTAND THAT PAYMENT FOR ALL OFFICE SERVICES IS PAYABLE ON THE DAY SERVICE IS RENDERED. AS IS STANDARD PRACTICE, FULL PAYMENT FOR ANY COSMETIC SURGERY AND ANY RELATED FEES WILL BE PAID THREE WEEKS PRIOR TO SURGERY. IF MY TREATMENT IS COVERED BY INSURANCE, I AUTHORIZE DR. MAROTTA TO BILL MY INSURANCE COMPANY AND RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM. IF MY INSURANCE COMPANY DOES NOT PAY FOR A TREATMENT RENDERED, I AM RESPONSIBLE FOR PAYMENT. I UNDERSTAND THAT MY CONTRACT IS BETWEEN DR. MAROTTA AND ME.

SIGNATURE _____ **DATE** _____

Marotta Facial Plastic Surgery
Medicare Patients Only – Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

Marotta Facial Plastic Surgery
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

_____
Signature

_____
Print Name Date

Marotta
FACIAL PLASTIC SURGERY

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(631) 982-2022

267 EAST MAIN ST. BUILDING B, SMITHTOWN, NY 11787

HEALTH INFORMATION AS OF _____ (ENTER TODAY'S DATE)

(PLEASE PRINT LEGIBLY & FILL IN ALL FIELDS)

PATIENT:

DOB	AGE	SS#

DO YOU NOW OR HAVE YOU EVER HAD..... (YOU MUST CIRCLE AN ANSWER FOR EACH INDIVIDUAL ITEM)

CONGESTIVE HEART FAILURE	YES	NO	BLADDER PROBLEMS, DIVERTICULUM OR STONE		
HEART ATTACK	YES	NO	DIALYSIS	YES	NO
CHEST PAIN	YES	NO	HEPATITIS	YES	NO
PALPITATION, IRREGULAR PULSE, OR ARRHYTHMIA	YES	NO	JAUNDICE (YELLOW SKIN)	YES	NO
HEART MURMUR OR HEART VALVE PROBLEM	YES	NO	GALLSTONES OR GALLBLADDER TROUBLE	YES	NO
OTHER HEART PROBLEMS	YES	NO	CIRRHOSIS OF THE LIVER OR LIVER FAILURE	YES	NO
ABNORMAL EKG	YES	NO	ESOPHAGEAL VARICES OR VOMITING BLOOD	YES	NO
HYPERTENSION OR HIGH BLOOD PRESSURE	YES	NO	FREQUENT INDIGESTION OR REFLUX (GERD)	YES	NO
ATHEROSCLEROSIS, POOR LEG CIRCULATION, PAIN IN THE LEGS WITH WALKING	YES	NO	STOMACH ULCERS OR GASTRITIS	YES	NO
SWELLING OR ULCERS ON THE LEGS	YES	NO	COLITIS OR DIVERTICULOSIS	YES	NO
SHORTNESS OF BREATH	YES	NO	SEVERE CONSTIPATION	YES	NO
ASTHMA	YES	NO	TARRY OR BLOODY BOWEL MOVEMENTS	YES	NO
BRONCHITIS	YES	NO	HEMORRHOIDS	YES	NO
PNEUMONIA	YES	NO	HERNIA	YES	NO
TUBERCULOSIS	YES	NO	GLAUCOMA	YES	NO
SMOKERS COUGH	YES	NO	VISUAL DISTURBANCES OR BLURRY VISION	YES	NO
EMPHYSEMA	YES	NO	WEAR CONTACTS OR GLASSES?	YES	NO
COUGHING OR SPITTING OF BLOOD	YES	NO	DRY EYE, EXCESSIVE TEARING OR GRITTY SENSATION IN EYES	YES	NO
OTHER LUNG PROBLEMS	YES	NO	DIFFICULTY BREATHING THROUGH YOUR NOSE	YES	NO
STROKE, TIA, OR "MINI-STROKE"	YES	NO	NASAL ALLERGIES OR HAY FEVER	YES	NO
SEIZURES OR CONVULSIONS OR FAINTING SPELLS	YES	NO	SINUS DISEASE (SINUSITIS) OR NASAL POLYPS	YES	NO
PALSY OR PARALYSIS OR WEAKNESS OF THE ARMS OR LEGS	YES	NO	TRAUMA OR INJURY TO THE NOSE OR FACE	YES	NO
NERVOUS BREAKDOWN OR DISORDER	YES	NO	RECURRENT NOSE BLEEDS	YES	NO
EATING DISORDER, ANOREXIA, BULIMIA	YES	NO	COLD SORES OR HERPES SIMPLEX VIRUS	YES	NO
INSOMNIA	YES	NO	FACIAL WEAKNESS OR BELL'S PALSY	YES	NO
ALCOHOLISM OR DRUG DEPENDENCY	YES	NO	BLOOD TRANSFUSION	YES	NO
SELF-DESTRUCTIVE TENDENCIES	YES	NO	POSITIVE BLOOD TEST FOR: HIV, AIDS, HEPATITIS	YES	NO
PSYCHIATRIC HOSPITALIZATION OR CARE	YES	NO	SKIN DISORDERS, ECZEMA, PSORIASIS, ANY DERMATITIS	YES	NO
RECENT DIVORCE OR LIFE CHANGING SITUATION E.G. DEATH IN THE FAMILY	YES	NO	POOR HEALING, KELOID, OR RAISED SCAR FORMATION	YES	NO
DIABETES	YES	NO	AUTOIMMUNE DISEASE, LUPUS, SCLERODERMA, SJOGREN'S OR WEGENER'S	YES	NO
HYPERTHYROIDISM ("OVER-ACTIVE THYROID")	YES	NO	CANCER OF ANY KIND, HISTORY OF CHEMOTHERAPY OR RADIATION THERAPY	YES	NO
HYPOTHYROIDISM ("UNDER-ACTIVE THYROID")	YES	NO	ARTHRITIS	YES	NO
GOITER	YES	NO	BACK OR NECK PAIN, SLIPPED DISK, OR FRACTURE	YES	NO
CUSHING SYNDROME	YES	NO	BLEEDING TENDENCY, ABNORMAL BLEEDING TEST, EASY BRUISING, OR EXCESSIVE BLEEDING DURING A PROCEDURE	YES	NO
KIDNEY OR RENAL DISEASE	YES	NO	FAMILY HISTORY OF BLEEDING DISORDER	YES	NO
ANY REACTION TO ANESTHESIA OR FAMILY HISTORY OF ANESTHESIA PROBLEMS	YES	NO	ANY HISTORY OF BLOOD CLOTS IN THE LEGS OR PULMONARY EMBOLISM	YES	NO
LOOSE TEETH	YES	NO	A CURRENT INFECTION OR ILLNESS	YES	NO
DENTURES, BRIDGES, CAPPED TEETH OR CROWNS, BONDING	YES	NO	PLANNED WEIGHT LOSS OF >15LBS. IN THE NEXT 3-6 MOS.	YES	NO

PLEASE PROVIDE BELOW ANY ADDITIONAL MEDICAL PROBLEMS (NOT LISTED ABOVE) YOU HAVE HAD OR HAVE NOW:

_____

_____

_____

PLEASE LIST ALL PRESENT MEDICATIONS, INCLUDING BIRTH CONTROL PILLS, HORMONES, AND VITAMINS, HERBAL MEDICATION, DIURETICS, WEIGHT LOSS DRUGS. PROVIDE AS MUCH DETAIL AS POSSIBLE INCLUDING DOSAGE AND TIMES OF DAY YOU TAKE THESE MEDICATIONS. **INCLUDE OVER-THE-COUNTER MEDICATIONS.**

_____

_____

_____

_____

DO YOU TAKE NOW OR HAVE YOU EVER TAKEN..... (YOU MUST CIRCLE AN ANSWER FOR EACH INDIVIDUAL ITEM)

A MULTIVITAMIN	YES	NO	GRAPE SEED EXTRACT	YES	NO
VITAMIN E (IN ADDITION TO A MULTIVITAMIN)	YES	NO	LICORICE ROOT	YES	NO
VITAMIN A (IN ADDITION TO A MULTIVITAMIN)	YES	NO	ST. JOHN'S WORT	YES	NO
ZINC (IN ADDITION TO A MULTIVITAMIN)	YES	NO	YOHIMBE	YES	NO
ASPIRIN, MOTRIN, IBUPROFEN, ADVIL OR OTHER NSAID	YES	NO	STEROIDS FOR ASTHMA OR ANY OTHER CONDITION E.G. CORTISONE	YES	NO
ANY DRUGS FOR ARTHRITIS, COLCHICINE	YES	NO	MONOAMINE OXIDASE INHIBITORS (MAOIS)	YES	NO
COUMADIN OR ANY OTHER BLOOD THINNER	YES	NO	ACCUTANE OR ISOTRETINOIN FOR ACNE OR RETIN-A	YES	NO
ALA – AMINO LEVULANIC ACID	YES	NO	DOXYCYCLINE	YES	NO
GINKOBILOBA OR GINKOBA	YES	NO	GLYCOLIC ACID, SALICYLIC ACID PRODUCTS OR PEELS	YES	NO

1. DO YOU HAVE AN ALLERGIC REACTION TO ANY MEDICATION? ☐ YES ☐ NO WHICH? _____
2. ARE YOU ALLERGIC OR HAVE YOU HAD ANY REACTION TO TAPE ADHESIVE? TO LATEX? ☐ YES ☐ NO WHICH? _____
3. DO YOU REACT ABNORMALLY TO ANY MEDICATION E.G. LOCAL ANESTHETICS OR EPINEPHRINE? ☐ YES ☐ NO WHICH? _____
4. DO YOU HAVE COCKTAILS REGULARLY, OR CONSUME REGULAR AMOUNTS OF ALCOHOLIC BEVERAGES, INCLUDING BEER, WINE, OR OTHER ALCOHOL?

   ☐ YES ☐ NO IF SO, HOW MUCH? _____
5. DO YOU SMOKE? ☐ YES ☐ NO IF SO, HOW MUCH? _____ FOR HOW LONG? _____
6. ARE YOU PREGNANT? ☐ YES ☐ NO ☐ NA WHEN WAS YOU LAST NORMAL MENSTRUAL PERIOD? _____
7. DO YOU HAVE REGULAR MENSTRUAL PERIODS? ☐ YES ☐ NO
8. IF YOU ARE A NEW MOTHER, ARE YOU CURRENTLY BREAST FEEDING? ☐ YES ☐ NO ☐ NA
9. HAVE YOU HAD ANY UNPROTECTED SUN EXPOSURE, USED TANNING CREAMS, OR TANNING BEDS IN THE LAST 4-6 WEEKS? ☐ YES ☐ NO
10. DO YOU HAVE ANY PERMANENT MAKE-UP, IMPLANTS, OR TATTOOS? ☐ YES ☐ NO WHERE? _____
11. FOR HAIR REMOVAL HAVE YOU DONE ANY PLUCKING, WAXING, TWEEZING OR ELECTROLYSIS IN THE PAST 6 WEEKS? ☐YES ☐ NO
12. PLEASE LIST ALL PHYSICIANS PRESENTLY CARING FOR YOU. LIST YOUR **PRIMARY CARE DOCTOR FIRST.**

    NAME ***TYPE OF DOCTOR (E.G. PRIMARY CARE)*** ***PHONE***

    _____

    _____

    _____
13. WHEN WAS YOUR LAST PHYSICAL EXAM? _____ BY WHOM? _____
14. HAVE YOU HAD ANY RECENT BLOOD WORK OR TESTING DONE? ☐YES ☐ NO WHERE? _____
15. PLEASE LIST ALL HOSPITALIZATIONS AND SURGERIES, INCLUDING **SURGERIES DONE FOR COSMETIC REASONS**:

    SURGICAL OPERATIONS

    TYPE OF OPERATION ***DATE*** ***SURGEON/LOCATION***

    _____

    _____

    _____

    _____

HOSPITALIZATIONS (EXCLUDING SURGERY)

REASON FOR ADMISSION *DATE* *HOSPITAL*

_____

_____

_____

16. PLEASE LIST ANY NON-SURGICAL COSMETIC PROCEDURES YOU'VE HAD IN THE PAST AND WHERE? EG. BOTOX -FOREHEAD, COLLAGEN- LIPS, CHEMICAL PEEL – FACE

_____

_____

17. WHAT BRINGS YOU TO SEE US?_____

18. ANY OTHER AREAS OR CONCERNS YOU WOULD LIKE THE DOCTOR OR STAFF TO ADDRESS:

☐ IMPROVE SKIN ☐ WRINKLES ☐ LASER HAIR REDUCTION ☐HAIR LOSS ☐ FOREHEAD OR BROWS ☐ EYES ☐ NOSE☐ CHIN

☐ CHEEKS☐ LIPS ☐ NECK ☐ EARS ☐ IMPROVE A SCAR ☐ VEINS OR BLOOD VESSELS ☐ REMOVAL OF SKIN LESION

19. ANY SPECIFIC PROCEDURE OR TREATMENT YOU'RE INTERESTED IN LEARNING MORE ABOUT?

_____

20. WOULD YOU LIKE A COMPLIMENTARY FORMAL SKIN EVALUATION? ☐ YES ☐ NO

BY SIGNING BELOW, I AGREE THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ DATE: _____

Marotta Facial Plastic Surgery
Skin Typing Form

Name: _____ Date: _____

Score		0	1	2	3	4
	What is your eye color?	Light blue or gray	Blue or green	Hazel, light brown	Dark Brown	Brownish black
	What is the natural color of your hair?	Red, Sandy red	Blonde	Dark blonde, chestnut, Brown	Dark Brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale w/beige tint	Light brown	Dark brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns
	To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed or self tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always

Add Above Column For Total Score	Match your total score with the corresponding skin type	Fitzpatrick Skin Type
	0-7	I
	8-16	II
	17-25	III
	26-30	IV
	Over 30	V-VI