Simona V. Pautler, M.D.
Aesthetic Plastic Surgery

Patient Registration Form/Health Questionnaire

PLEASE PRINT CLEARLY

Name ____
Last LEGAL First Middle Name

Address ____
Street and Number City State Zip Code

Phone Number to use FIRST to contact you (_____) _________________

Can we leave a message? Yes No Can we text your cell phone? Yes No Can we Email you? Yes No

Cell Phone ( ) ____________________________ Home Phone (___) _______________________________

Work Phone (___) ___________________________ Email Address __________________________________

Date of Birth ____________________________ Age ________ Sex F M

Marital Status S____ M____ D____ W___ Sep ____

Social Security # ___________________________ Maiden Name_____________________________

Occupation ____

Patient's Employer _______________________________ Phone (___) ___________________________

Spouse's Name ________________________________ Phone (___) _____________________________

In Emergency Notify_____________________________ Phone (___) _____________________________

Family Physician ________________________________ Phone (___) ____________________________

Reason for visit ____

Referred by ____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any and all procedures that I grant Dr. Simona Pautler to do. ***I understand that Dr. Pautler does not accept Assignment of Insurance for any carrier and we are NOT NETWORKED with any carriers****. Services will be paid by you at the time of service. It is standard procedure for Dr. Pautler and/or her staff to take pre- and post-operative photographs of her patients. I hereby authorize Dr. Pautler to take my photograph and use it in my chart and for patient education.*

____ ____________________
Signature of Responsible Party *Date*

☐ *Photo ID and address verified Date:* ___________________

☐ *Address Updated? Date:* ___________________

MEDICAL HISTORY

Height ______________________ Weight _________________________

Are you or could you be pregnant? Yes No # of Pregnancies_____ # of Children _____ Ages _________________

Are you allergic to any medicines? Yes No If so, please list:

____

Are you allergic to adhesives or adhesive glue? ____

Do you have an allergy to latex? Yes No Tested for latex allergy? Yes No If so, where? ______________________________

Do you have/have a history of any of the following?

Musculoskeletal:		Ulcers	☐Yes ☐No
Arthritis/ Osteoporosis	☐Yes ☐No	IBS	☐Yes ☐No
Immobilizing Cast/Fracture	☐Yes ☐No	Trouble Swallowing	☐Yes ☐No
Fibromyalgia	☐Yes ☐No	**ENT:**	
Spinal Stenosis	☐Yes ☐No	Cataracts	☐Yes ☐No
Respiratory:		Macular Degeneration/Glaucoma	☐Yes ☐No
Asthma	☐Yes ☐No	Sinusitis	☐Yes ☐No
Bronchitis	☐Yes ☐No	Hearing Impairment	☐Yes ☐No
Pneumonia	☐Yes ☐No	**Endocrine:**	
COPD	☐Yes ☐No	Diabetes-Insulin, Oral, Diet Control	☐Yes ☐No
Sleep Apnea (C-PAP/BIPAP use)	☐Yes ☐No	Hypoglycemia	☐Yes ☐No
		Thyroid Disease	☐Yes ☐No
Cardiac:		Hypothyroid	☐Yes ☐No
Heart Attack	☐Yes ☐No	**Neurological:**	
Cardiac Stent/Pacemaker/Defibrillator	☐Yes ☐No	Migraine Headaches	☐Yes ☐No
Congestive Failure	☐Yes ☐No	Seizures last seizure:	☐Yes ☐No
Mitral Valve Prolapse	☐Yes ☐No	Stroke/Mini-Stroke	☐Yes ☐No
Murmur	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	**Cancer:**	
High Cholesterol	☐Yes ☐No	Area Affected:	
		Chemo/Radiation	☐Yes ☐No
Vascular:		**Chemical Dependence**	☐Yes ☐No
Carotid Artery Disease	☐Yes ☐No	Alcohol/Drugs (past/current)	☐Yes ☐No
Vascular Disease	☐Yes ☐No	**Psychological:**	
Aneurysm	☐Yes ☐No	Anxiety/Depression/Bipolar	☐Yes ☐No
Blood Clots--leg or lungs (self)	☐Yes ☐No	Treated	☐Yes ☐No
Blood Clots—leg or lungs (family)	☐Yes ☐No		
Varicose Veins/Leg Swelling/Ulcers	☐Yes ☐No	Dementia/Alzheimer's	☐Yes ☐No
Blood Disorders:		**Infection Control:**	
Anemia	☐Yes ☐No	Hepatitis	☐Yes ☐No
Bleeding/Clotting Disorders	☐Yes ☐No	Sexually Transmitted Diseases	☐Yes ☐No
Renal:		Herpes-genital	☐Yes ☐No
UTI	☐Yes ☐No	Shingles	☐Yes ☐No
Kidney Stones	☐Yes ☐No	AIDS/HIV Exposure	☐Yes ☐No
Kidney Failure/Dialysis	☐Yes ☐No	**Skin:**	
Prostate Problems	☐Yes ☐No	Eczema/Psoriasis	☐Yes ☐No
Gastrointestinal:		Pressure Ulcer	☐Yes ☐No
Reflux	☐Yes ☐No	**Recent weight gain/loss of more than 10 lbs** ☐Yes ☐No	
Hernia hiatal/inguinal	☐Yes ☐No	**Other:**	
Diverticulosis	☐Yes ☐No	Other:	

If you answered yes to any of the above, please explain your answer below:

____

____

Do you take vitamins or herbal supplements? Yes No If so, please list: ____

____

____

Current medications ____

____

____

Do you take birth control pills? Yes No Type ____

Do you have any implants or prosthetic devices? ____

____

Have you ever had C. Difficile? ☐Yes ☐No **Have you ever had MRSA?** ☐Yes ☐ No Testing

Where?____

Have you ever had VRE? ☐Yes ☐No Testing Where?____

Pharmacy name, zip code & Phone Number *Required ____

FAMILY HISTORY

Is there any immediate family history of cancer, heart disease, diabetes, hypertension, genetic conditions or **a history of pulmonary emboli or blood clots**? Yes No

If Yes, explain ____

____

Have you or any family member had problems with anesthesia? Yes No

If Yes, explain ____

____

SOCIAL HISTORY

Do you exercise regularly? Yes No If so, how? ____

Have you ever smoked? Yes No If yes, do you still smoke? Yes No Quantity/day ____________________

Do you drink alcoholic beverages? Yes No Quantity/day ________________

Do you use recreational drugs? Yes No

Type of drug(s) used: ____

Date last used: ____

SURGICAL HISTORY:

NON-COSMETIC SURGERIES

Please list all NON-COSMETIC surgeries:

1 ____ Date_____________________

2 ____ Date_____________________

3 ____ Date_____________________

4 ____ Date_____________________

COSMETIC HISTORY

Please list all COSMETIC surgeries and the SURGEONS who performed them:

1 ____ Date_____________________

Surgeon: ____

2 ____ Date_____________________

Surgeon: ____

3 ____ Date_____________________

Surgeon: ____

COSMETIC INJECTABLE TREATMENTS:

Have you ever had filler injections (i.e. Collagen, Restylane, Juvederm, fat, etc)? Yes No

Date of last injection: _____________________ What areas? ____

Any problems? ____

____

Have you ever had Botox injections? Yes No How many times? _______________

Date of last injection: _____________________ What areas? ____

____

Any problems? ____

____

Have you ever had a non-surgical skin treatment? Yes No Describe: __________________________________

____

DIRECTIONS TO OUR OFFICE

Dr. Pautler's office is located about 5 miles south of the South Hills Village Shopping Mall on Route 19 (Washington Road). If you travel from the north on Route 19, you will pass the mall on your left, about 4.5 miles later you will also pass on your left first a funeral home, then the PPG paint store, and then we are the next building on the left, directly across from the South Hills Jeep dealer. We are in the orange brick building with the Original Mattress Factory sign and our logo. We are on the second floor. Once you see PPG Paint, slow down and get into the left turning lane. As you turn into the parking lot, *DON'T park* in the front of the building. Instead, head towards the right of the building up a short hill and to the private (and free!) parking lot in the back. The entrance to our office is located there.

If you are traveling from the south on Route 19, we are about 3 miles north of the King's Restaurant on the right. You will first pass a large Lutheran church at the intersection between Route 19 and Gateshead Drive, then the Ace Plaza. At this point, slow down and prepare to turn right, just across from the South Hills Jeep dealer.

If you are traveling off of Interstate 79, you will need to take the Canonsburg exit, which takes you to McClelland Road. Turn left on McClelland Road until you reach King's Restaurant and Route 19 and then turn left and head north as above.

If you have any problems locating our office, please feel free to call us at (724) 969-0930.

*** Please note – if using a GPS Unit, our address is:

3311 Washington Road, *Canonsburg*, PA 15317

GPS Units do not recognize *McMurray*, PA

FREQUENTLY ASKED QUESTIONS

1. How much time will I spend at the office?

   Expect to spend approximately an hour or hour and a half. You will first meet briefly with our nurse Nadine and then with Dr. Pautler for about 45 minutes to an hour. Then you will meet with our patient care coordinator Kathy to discuss your quote.

2. What is the cost for a consultation?

   Our consultation fee is $250.00. This fee is put towards the surgical procedure, should you proceed. It is our office policy that the consult fee is paid in advance of your appointment. ***This fee will be refunded to you should you need to cancel your appointment within 48 hours of your scheduled appointment.***

3. What happens during my consultation with Dr. Pautler?

   Our nurse Nadine will review with you your health history. Dr. Pautler will examine you and explain details of the surgery you are considering, whether or not you are a candidate, the risks and benefits, and key points of the recovery process. You will also be able to view before and after photos of Dr. Pautler's work.

4. Does the Doctor do any surgery in the office?

   Dr. Pautler performs minor surgeries in the office that require only a local anesthetic. This includes upper eyelid contouring surgery, fat injections, and small liposuction procedures.

5. What happens if I cannot make my appointment?

   As a courtesy, we make reminder calls to our new patients a week before their scheduled appointment. We ask that the patient return our call to confirm their appointment. It is the responsibility of the patient to inform us of any changes in their personal information such as phone numbers, mailing address, e-mail address and any other pertinent information. In consideration of our scheduled patients, we ask that each patient make every effort to be on time to their appointment. If an appointment needs to be canceled or rescheduled, we require a 24 hour notice otherwise the patient will be considered a no-show appointment. This courtesy, on your part, will make it possible to give your appointment to another patient.

Simona V. Pautler, M.D., F.A.C.S.

And Affiliated Associates

Warning Regarding HIPAA and Email/Text Communications

Dr. Simona Pautler and her practice take every step possible to maintain your privacy and to stay compliant with all HIPAA laws. However, with current technology it is not possible to ensure complete privacy between you and our practice for email and text communications. In other words, if you are to text or email any of your medication information or photos to our practice it cannot be guaranteed that all the information is compliant with HIPAA privacy laws, and it is possible that some if it could be inadvertently exposed. For this reason, we want to make clear that HIPAA compliance is not possible for all text and emails between you and either Dr. Pautler or any of her staff and you should be warned of the possibility of sensitive information being unprotected.

Your signature below memorializes your understanding of this important issue.

____ ________________

Patient Signature Date

Simona V. Pautler, M.D., F.A.C.S.

and Affiliated Associates

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, and health care operations (TPO) and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health conditions and related health services.

Uses and Disclosures of Protected Health Information. Your protected health information (PHI) may be used and disclosed by your Physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.
Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may call you by your name in the waiting room when Dr. Pautler is ready to see you. We may disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Connunicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroner's, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates – required Uses and Disclosures, under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to Investigate or determine our compliance with the requirements of Section 164.500.
Other Permitted and Required Uses and Disclosures will be made only with your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.
Your rights: Following is a statement of your rights with respect to your protected health information.
You have the right to request a restriction of your protected health information: Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes: information complied in reasonable

anticipation of, or use in, a civil, criminal or an administration action or proceedings, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This m3eans you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare options. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.
We reserve the right to change terms of this
notice and will inform you by mail of any changes, you then have the right to object or withdraw as provided in this notice.
Complaints: You may complain to us or to the Secretary of Health and Human Servies if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by telephone at our main telephone numbers (724) 969-0930.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

______________________________ ______________

Patient Name Date

______________________________ ______________

Witness Date

This Notice was published and becomes effective on/or before August 13, 2024