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

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 Address & 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: _____

_____

SIMONA V. PAUTLER, MD, FACS

3311 Washington Road, Suite 200
McMurray, PA 15317

Phone: 724-969-0930 Fax: 724-969-0428

Consent to Use and Disclose Health Information For Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, Dr. Simona Pautler originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment, I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that the Practice 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've 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 and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Print Name Relationship to Patient

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement.
- ❑ An emergency situation prevented us from obtaining acknowledgement.
- ❑ Other (Please specify) _____

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 $100.00. 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.