John M. Trupiano, MD, FACS
Board Certified Plastic Surgeon
201 West Big Beaver Road, Suite 1050
Troy, MI 48084
Phone: (248) 220-3310
Fax: (248) 220-3311

Patient Intake Form

Date of visit: _____

Last Name: _____ First Name: _____ M.I.: _____

Date of Birth: _____ Age: _____ SS#: _____

Street Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip: _____

Cell Phone:_____ Home Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

Street Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip: _____

Work Phone: _____

Emergency Contact Name: _____ Relationship: _____

Cell Phone: _____

Did a physician refer you to Dr. Trupiano? ☐ Yes ☐ No

Name: _____ Specialty: _____ Phone: _____

If you were not referred by a physician, how did you hear about Dr. Trupiano?

☐ Friend/Family: _____
☐ DrTrupiano.com
☐ Internet Search/Google
☐ Instagram
☐ Facebook
☐ RealSelf.com
☐ Other: _____

Allergan/Brilliant Distinctions account number: _____

Password: _____

Galderma/Aspire account number: _____

Password: _____

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Patient Insurance Awareness

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to check with your insurance company prior to any office or hospital procedures. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred during your office visit. Please remember – ***your insurance policy is between you and your insurance company and not between the insurance company and your doctor***. Also, please be advised that lab work performed in the office is a separate charge from the physician's charges.

Dr. Trupiano has no control over your insurance plan regarding co-pays, deductibles, and coinsurance. It is your responsibility to be familiar with your insurance plan(s) prior to proceeding with your consult and/or procedure. ***It is for this reason, co-pays, deductibles, and coinsurance will be collected prior to being seen by Dr. Trupiano and/or before any surgical procedure that is performed***.

Your signature below verifies that you have read and understand this statement and all your questions have been answered.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Name of Patient or Legal Guardian

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HIPAA Consent for Purposes of Treatment, Payment, and Healthcare Operations

With my consent, John M. Trupiano, M.D., P.C. may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to John M. Trupiano, M.D., P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

My Protected Health Information means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This Protected Health Information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. And, that John M. Trupiano, M.D., P.C. reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to John M. Trupiano, M.D., P.C., Attn: Privacy Officer, at 201 West Big Beaver road, Suite 1050, Troy, MI 48084.

With my consent, John M. Trupiano, M.D., P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and prescriptions among others.

With my consent, John M. Trupiano, M.D., P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, John M. Trupiano, M.D., P.C. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that John M. Trupiano, M.D., P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to John M. Trupiano, M.D., P.C. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, John M. Trupiano, M.D., P.C. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

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VIDEOTAPE AND PHOTOGRAPHS RELEASE AND AUTHORIZATION

I hereby irrevocably consent to and authorize the use and reproduction by the John M. Trupiano, M.D., P.C., the American Society of Plastic Surgeons (ASPS) and its affiliates, or anyone authorized by any of them, of any and all photographs, electronic images or video footage of me taken by ASPS, or that ASPS has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including John M. Trupiano M.D., P.C. website, the ASPS website and social media sites such as YouTube, Instagram, Facebook and Twitter. The Images (including any photographic negatives) shall be the sole property of John M. Trupiano M.D., P.C. and ASPS. John M. Trupiano M.D., P.C. and ASPS also shall have the right to use my name in connection therewith if it so chooses.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge and agree to hold harmless John M. Trupiano M.D., P.C. and ASPS and their affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I hereby warrant that I am over eighteen years of age, and competent to contract in my own name insofar as the above is concerned.

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Date: _____ Printed Name: _____

Signature: _____

I have read the above Release and Authorization. I am the parent, guardian, or conservatory of _____, a minor. I am authorized to sign this authorization on his/her behalf, and I give this authorization in the interest of public education.

Date: _____ Printed Name: _____

Signature: _____

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Patient Name: _____ **Date of visit:** _____

Medical History: Check the conditions which apply to you. Write the approximate year of occurrence or onset next to each checked condition.

✓	Year	Condition	✓	Year	Condition	✓	Year	Condition
		Anemia			Deep Vein Thrombosis (DVT)			High Blood Pressure
		Anesthetic Reaction			Diabetes (Insulin: Y/N)			High Cholesterol
		Angina/Chest Pain			Drug Dependency			Hypoglycemia
		Arthritis			Emphysema			Hypothyroidism
		Asthma			GERD/Acid Reflux			Irregular Heartbeat
		Bladder Infection			Glaucoma			Kidney Problems
		Bleeding Problem			Headaches/Migraines			Paralysis
		Blood Transfusion			Hearing Problems			Seizures/Convulsions
		Breathing Problem			Heart Attack			Skin Disorders
		Bronchitis			Heart Failure			Stroke
		Cancer (type:)			Heart Murmur			Ulcers
		Circulation Problem			Hepatitis/Jaundice			Tuberculosis
		Cirrhosis			Hiatal Hernia			Other:

Operations and Hospitalizations: List all prior operations that you have had and medical problems for which you have been hospitalized. Give approximate year of occurrence.

Year	Operation/Medical Problem	Year	Operation/Medical Problem

Medications: List ALL medications, prescription and non-prescription (SUPPLEMENTS, HERBAL TEAS, ETC.) you are presently taking. Include frequency and dose.

Medication	Dose	Frequency	Medication	Dose	Frequency

Allergies: List all known drug allergies and reaction.

Allergic To:	Reaction	Allergic To:	Reaction

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Patient Name: _____ **Date of visit:** _____

Social History:

Marital status:	☐ Single	☐ Married	☐ Divorced	☐ Widowed
Tobacco use:	☐ Never	☐ Quit ____ years ago	☐ Packs per day ___	How many years? ___
Alcohol use:	☐ Never	☐ Rarely	☐ Moderate	☐ Daily
Street drug use:	☐ Never	☐ Type _____	Frequency _____	

System Review: Please check Yes or No for each item.

Height: _____ **Weight:** _____

General Symptoms

Good general health lately	☐Yes	☐No
Fatigue	☐Yes	☐No

Eyes

Glaucoma	☐Yes	☐No
Cataracts	☐Yes	☐No
Visual changes	☐Yes	☐No

Ears/Nose/Mouth/Throat

Chronic sinus problems	☐Yes	☐No
Sore throat	☐Yes	☐No
Swollen glands in neck	☐Yes	☐No

Cardiovascular

High blood pressure	☐Yes	☐No
Chest pain/angina	☐Yes	☐No
Pacemaker	☐Yes	☐No

Respiratory

Chronic or frequent cough	☐Yes	☐No
Shortness of breath	☐Yes	☐No
Sleep apnea	☐Yes	☐No
Asthma	☐Yes	☐No
Emphysema	☐Yes	☐No
Tuberculosis	☐Yes	☐No

Breasts

Pain in breasts	☐Yes	☐No
Discharge from nipple(s)	☐Yes	☐No
Breast mass/lump	☐Yes	☐No
Previous breast surgery	☐Yes	☐No
Regular mammograms	☐Yes	☐No

Date of last mammogram: _____

Gastrointestinal

Poor appetite	☐Yes	☐No
Nausea or vomiting	☐Yes	☐No
Frequent diarrhea	☐Yes	☐No
Constipation	☐Yes	☐No
Blood in stool	☐Yes	☐No

Genitourinary

Frequent urination	☐Yes	☐No
Blood in urine	☐Yes	☐No
Incontinence/dribbling	☐Yes	☐No
Kidney failure/dialysis	☐Yes	☐No
Kidney transplant	☐Yes	☐No
Discharge from penis/vagina	☐Yes	☐No

Integument (Skin)

Bleeding or bruising tendency	☐Yes	☐No
Change in mole	☐Yes	☐No

Musculoskeletal

Joint pain	☐Yes	☐No
Joint stiffness	☐Yes	☐No
Weakness of muscles or joints	☐Yes	☐No
Back pain	☐Yes	☐No
Osteoarthritis	☐Yes	☐No

Neurological

Frequent/recurring headaches	☐Yes	☐No
Lightheaded or dizzy	☐Yes	☐No
Fainting or unconscious spells	☐Yes	☐No

Endocrine/Hepatic

Excessive thirst/urination	☐Yes	☐No
Diabetes	☐Yes	☐No
Heat/cold intolerance	☐Yes	☐No
Thyroid disease	☐Yes	☐No
Hepatitis	☐Yes	☐No

Hematologic/Lymphatic

Anemia	☐Yes	☐No
Bleeding disorder	☐Yes	☐No
Clotting disorder	☐Yes	☐No
Human Immunodeficiency Virus	☐Yes	☐No

Psychiatric

Depression	☐Yes	☐No
Anxiety	☐Yes	☐No
Claustrophobia	☐Yes	☐No

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Procedure Information

What procedure(s) are you interested in having:

BREAST	BODY
☐ Breast Augmentation	☐ Mommy Makeover
☐ Breast Lift (Mastopexy)	☐ Abdominoplasty (Tummy Tuck)
☐ Breast Reduction	☐ Liposuction
☐ Male Breast Surgery (Gynecomastia)	☐ Body Lift
☐ Breast Implant Exchange	☐ Brachioplasty (Arm Lift)
☐ Breast Capsulectomy/Implant Removal	☐ Thigh Lift
☐ Breast Revision/Repair	☐ Buttock Enhancement (Brazilian Butt Lift)
☐ Breast Asymmetry	☐ Fat Transfer
☐ Areolar Reduction	☐ Labiaplasty (Reduce Labia Minora)
☐ Inverted Nipple Repair	☐ Vaginal Rejuvenation/Vaginal Tightening
☐ Other:	☐ Other:
FACE	**SKIN**
☐ Facelift	☐ Wrinkle Reducers (Botox, Dysport, etc.)
☐ Neck Lift	☐ Facial Fillers/Injectables/Liquid Facelift
☐ Brow Lift	☐ Fat Injections
☐ Upper Eyelids (Blepharoplasty)	☐ Skin Resurfacing
☐ Lower Eyelids (Blepharoplasty)	☐ Skin Tightening Laser
☐ Otoplasty (Ear Reshaping/Pinning)	☐ Hand Rejuvenation
☐ Earlobe Repair	☐ Lesions/Moles
☐ Facial Fat Transfer	☐ Cyst
☐ Lip Augmentation	☐ Lipoma
☐ Other:	☐ Other:

Other unlisted procedure: _____

Please describe why you are interested in having the procedure(s) listed above: _____

_____

_____