edwin cortez, md
facial plastic surgery

Patient Information

Name _____ Date _____

Email address _____

Would you like to receive emails about new products and procedures? Yes_____ No_____

Date of Birth _____ Age _____ Wt _____ Ht_____

Address_____ City _____

State _____ Zip _____ Telephone _____

Employer _____ Telephone _____

Work Address_____

May we contact you at work? Yes_____ No _____

Please circle: Single Married Divorce Separated Ages of children_____

Name of nearest relative _____ Relationship _____

Telephone _____ Work telephone _____

Family Physician _____ Telephone _____

Dermatologist_____ Telephone_____

Eye Doctor _____ Telephone _____

Preferred Pharmacy _____ Telephone _____

Who referred you to us? _____

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Please list any allergies you have and reactions: _____

_____

Please list all current medications, vitamins, and herbal supplements you are taking with the DOSAGE & FREQUENCY:

_____

_____

_____

Please list any past surgeries and the dates they were performed: _____

_____

_____

Please circle if you have had or currently have any of the symptoms below:

CHEST PAIN	HEADACHES	BLOOD IN URINE
DIZZINESS/FAINTING	LOOSE TEETH	KIDNEY PROBLEMS
VISUAL DISTURBANCES	CHRONIC COUGH	BLADDER PROBLEMS
SHADING OVER EYE	BLOODY SPUTUM	STROKE-LOSS OF USE OF HAND OR LEG
SHORTNESS OF BREATH	GLAUCOMA	
SEIZURES	DENTURES	
RECTAL BLEEDING	EXCESSIVE BRUSING	
STOMACH PAIN	COLD SORES/FEVER BLISTERS	
SKIN INFECTIONS/RASHES	HEPATITIS/JAUNDICE	

Please circle any of the following conditions that you are presently being treated for:

ASTHMA	ARTHRITIS	EPILEPSY	TUBERCULOSIS
DIABETES	HEART ATTACK	LIVER DISEASE	COPD
HEART PROBLEMS	ACNE	KIDNEY DISEASE	HIV
HIGH BLOOD PRESSURE	EMOTIONAL PROBLEMS	EXCESSIVE SCARING	MRSA
BLOOD DISORDER/ANEMIA	STOMACH ULCERS	THYROID PROBLEMS	
HEMORRHOIDS	CANCER	INJURIES	

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Please answer the following:

NO YES Have you ever received local anesthesia (Novocain, Lidocaine, etc.) by a dentist or doctor?

NO YES Did you have a reaction? If so please list _____

NO YES Have you ever received radiation treatments on any area of the head or neck?

NO YES Have you in the past or do you currently use steroid creams?

NO YES Have you ever received treatment for your genital area?

NO YES Do you smoke more than 10 cigarettes per day?

NO YES Do you drink more than 6 cups of coffee per day?

NO YES Do you usually have 2 or more alcoholic drinks per day?

NO YES Are you frequently sick or ill?

NO YES Does criticism always upset you?

NO YES Do you worry about your health?

NO YES Are you easily upset or irritated?

NO YES Do you tend to hold a grudge when someone angers you?

NO YES Have you ever considered consulting a psychiatrist or psychologist, or have you ever been under the care of a psychiatrist or Psychologist? If yes, please explain:

_____

NO YES Do you have any other medical problems that have not been covered? If yes, please explain:

_____

WOMEN ONLY: Date of your last menstrual period? ____Currently Pregnant?_____ Currently Breastfeeding?_____
NO YES Are you periods often irregular?
NO YES Have you had any "female" or GYN problems? If yes, please explain:

_____

NO YES Do you take any hormones? Please list:

_____

MEN ONLY: Have you had any prostate problems? If so, please list:

_____

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What procedures are you interested in?

____ Rhinoplasty ____Chemical Peel ____Botox ___Laser (Broken Capillaries)

____Chin ____Eyelids ____Filler ____Brow lift

____Scar Revision ____Face or Neck Lift ____Skin Care

____Removal of cysts, moles etc. ____Ears (Lobe Repair, Protruding)

_____Other_____

What specifically do you wish to have corrected?

_____

_____

When did you begin to consider surgical correction? _____

Why have you decided to have it done at this point in time?

_____

Have you consulted with any other doctors about this? If so, when? _____

Have you discussed this surgery with your family? _____ Are they agreeable? _____

Have you had any previous cosmetic or reconstructive surgery? If so, please explain_____

_____

Who performed the surgery? _____ Where and when was it done? _____

Were you satisfied with the results? _____If not, please explain why: _____

_____

Have you had any other surgery or an injury to the face, nose, neck or eyes? If so, please list with dates:

_____

Signed _____ Date _____

THANK YOU!
The information you have provided is essential in our comprehensive evaluation of your case

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
TELEPHONE CONSENT FORM

Completion of this document authorizes the disclosure and/or use of health information about you. The purpose is to give your health care provider permission to leave certain health information on your phone messaging service. Failure to provide all information requested may invalidate this authorization.

Name of Patient: _____

USE AND DISCLOSURE OF HEALTH INFORMATION
I hereby authorize: The Staff at Cortez Facial Plastic Surgery
To be able to call telephone number(s): _____and leave a detailed message/voicemail with the following information:

- ☐ Lab and test results
- ☐ Pathology results
- ☐ Details about my upcoming appointment(s) (physician name and date(s) as well as specific appointment reminders)
- ☐ Only the following records or types of health information (including any dates):

_____
_____

- ☐ I DECLINE. Please do not leave any messages.

MY RIGHTS
I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
If the health information is being disclosed or used, I may inspect or obtain a copy of this health information.
I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: 14241 Metcalf Avenue, Overland Park, KS 66223
My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPPA).

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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ONLINE COMMUNICATION

Online communication is a form of communication using "secure" Web sites or e-mail applications that apply appropriate encryption technology designed to protect the transmission of confidential information. Online communication is an additional option for communication along with telephone, mail, and in-person. It is not meant to replace other forms of communication with the doctor.

-The details of online communication have been explained to me in terms I understand.

-Alternative methods of communication (i.e., telephone, etc) are still available to me.

-I understand that all medical communications carry some level of risk. While the likelihood of risks associated with the use of online communication in a secure environment is substantially reduced, the risks are nonetheless real and very important to understand. These risks include, but are not limited to:

- It is easier for online communication to be forwarded, intercepted, or even changed without my knowledge.
- Online communication is easier to falsify than handwritten or signed hard copies. Backup copies may exist on a computer or in cyberspace, even after both of us have deleted our copies.
- I will use a secure network. I will not use standard e-mail or e-mail systems provided by employers. I understand that employers have a right to inspect and keep online communication transmitted through their system.
- Online communications become part of my medical record.

-I agree to take precautions to keep online communication confidential, including but not limited to the following:

- I will keep my password confidential. I will not store messages on an employer-provided computer. I will not leave messages on my screen for others to read. I will review my messages before sending to make sure that they are clear and that all relevant information is included. I will update my contact information as soon as it changes.

-I understand that I am responsible for taking steps to protect myself from unauthorized use of online communication. The doctor is not responsible for breaches of confidentiality caused by an independent third party or me.

-I agree to follow the procedures that the doctor implements to allow him/her to verify my identity in connection with online communication. I acknowledge that failure to comply with these procedures may terminate our online communication.

-I understand that online communication cannot be used for emergencies or time sensitive matters.

-I understand that it is my responsibility to determine if an unanswered online communication was received.

-I acknowledge that I have read and fully understand this consent form, including risks associated with online communication.

Please fill in the following:

I agree to the terms for online communication between: Dr. Edwin Cortez, Dr. William R. Thornton, office staff and _____.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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CANCELLATION POLICY
Consultations

Cancellations or reschedules with less than 48 hours notice, will be required to pre-pay a non-refundable consult fee for the rescheduled appointment.

We understand that life can be a little unpredictable. Therefore, we ask that you provide us with at least 48 hours notice for cancellations. Please understand that when you cancel your appointment without giving us enough notice, we miss the opportunity to fill that appointment time and patients on our waiting list may miss a chance to receive services they have been waiting to schedule. We appreciate you understanding the value of your appointment time.

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A checklist for your cosmetic facial surgery consultation
Below are Dr. Cortez's responses

Is the majority of the surgeon's practice devoted to cosmetic surgery? YES-95%

Does the doctor limit himself to or have a special interest and experience in cosmetic surgery of the face and neck only? YES

How long has the doctor been performing the procedures you are considering? OVER 30 YEARS

Does the doctor have hospital privileges to perform the procedures you are considering? YES

How many of these procedures does the doctor perform in an average week? 4-5 MAJOR PROCEDURES

Has the doctor completed a cosmetic facial surgery fellowship? YES

Is the doctor board certified? YES

Is the doctor a fellow of the American College of Surgeons? YES

Has the doctor been a medical school faculty member? YES

Is the doctor a member of local, state and national medical societies? YES

Has the doctor written books or authored journal articles on cosmetic facial surgery? YES

Does the doctor teach other doctors in his techniques of cosmetic facial surgery? YES

Can you receive a copy of the doctor's professional biography summarizing his training, qualifications and credentials? YES

Are typical 'before and after' photos made available for your viewing? YES

Does the office provide 'computer imaging' to help you envision and understand Dr. Cortez's aesthetics? YES

Is transportation available to and from the facility? NO

Does the office provide, at the consultation, an itemized 'fee quotation sheet' listing all of the proposed services and charges? YES

Does the office offer a financing program? NO Does this facility participate in Medicare? NO

Can you speak with a patient who has had surgery performed by the doctor? YES

Is the facility accredited? YES – AAAASF (The American Association for Accreditation of Ambulatory Surgery Facilities, Inc.)

Does the facility have an accredited operating room on site? YES

Who administers anesthesia? CRNA (Certified Nurse Anesthetist)

Is the surgery performed entirely by your surgeon, or is part delegated to a surgeon-in-training? SURGEON ONLY

Will the doctor and the nursing staff perform all of the postoperative care? YES

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