Grigoriy Mashkevich, MD

Facial Plastic & Reconstructive Surgery

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PATIENT INFORMATION

Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____ Age: _____

Name: _____
Last First Initial

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ N/A

If Minor: Mother's Name_____ Father's Name_____

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Other Phone: (_____) _____

Preferred Phone Number: ☐ Home ☐ Cell ☐ Other **Preferred Contact Method**: ☐ Phone ☐ Email ☐ Either

Employer:_____ Occupation: _____

Emergency contact: _____ Phone: (_____) _____

How were you referred to us? ☐ Newspaper/Magazine: _____

☐ Internet: ☐ Google ☐ Realself.com ☐ AAFPRS.org ☐ NYEE.edu ☐ Other: _____

☐ Friend or Relative: _____ ☐ Physician _____

May we thank the person for referring you? ☐ Yes ☐ No

Are you interested in receiving new information, invitations to events, discounts, or promotions in the future? ☐ Yes ☐ No

For Insurance Visits Only – INSURANCE INFORMATION

Insurance Subscriber:_____ Relation to Patient:_____
(if other than patient)

Address: _____ Phone: (_____)_____
Street & Suite/Apt # City State Zip

Do you have Medicare? ☐ Yes ☐ No
Medicare ID#: _____

Are you seeking care in relation to an accident? ☐ Yes ☐ No
As a result of work? ☐ Yes ☐ No

Primary Insurance Company: _____ Subscriber ID#:_____ Group #_____

For Insurance Visits Only – ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Grigoriy Mashkevich, MD for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ **Date**: _____

MEDICAL HISTORY QUESTIONNAIRE

Reason for your visit: ☐ Brows/Eyes ☐ Face/Neck ☐ Nose/Breathing ☐ Skin ☐ Hair/Veins ☐ Other: _____

Personal Physician

Are you under a doctor's care? ☐ Yes ☐ No Physician Name:_____

Address: _____ Phone (_____)_____

Medical History

What medical conditions are you presently being treated for?

Do you have (or have you ever had) any of the following?

	YES	NO		YES	NO		YES	NO
Asthma or emphysema	☐	☐	Easy bleeding / bruising	☐	☐	Rheumatic fever	☐	☐
Shortness of breath	☐	☐	HIV/AIDS	☐	☐	Heart murmur	☐	☐
Heart disease	☐	☐	Liver disease / hepatitis	☐	☐	Seizure	☐	☐
Chest pain	☐	☐	Fainting	☐	☐	Stroke	☐	☐
High blood pressure	☐	☐	Diabetes	☐	☐	Other	☐	☐
Pacemaker/defibrillator	☐	☐	Depression/Anxiety	☐	☐	_____		

If you are considering nasal surgery, have you ever had any of the following?

Difficulty breathing	☐	☐	Crusting	☐	☐	Polyps	☐	☐
Sinus infections	☐	☐	Nasal allergies	☐	☐	Trauma	☐	☐
Nose bleeds	☐	☐	Whistling sounds	☐	☐			

Surgical History

Please list all previous operations, including dates:

Allergies

Are you allergic or have any sensitivity to medications, drugs, or anesthetics? If so, please list the name(s) of the medications and your body's reaction:

MEDICATION	REACTION
_____	_____

Medications

List all medications you are currently taking, including over the counter products (aspirin, herbs, etc):

MEDICATION	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Tobacco: ☐ Never ☐ Currently smoke ___ packs/day (___ years) ☐ Former smoker (quit ___ years ago)

Alcohol consumption: ☐ Never ☐ Occasionally ☐ Regularly: _____ drinks per day

Scarring

Do you form thick or raised scars (keloids) from cuts or burns? ☐ Yes ☐ No

Have you ever formed excessive or unsatisfactory scars in the past? ☐ Yes ☐ No

Pregnancy

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Skin History

Do you have (or have you ever had) any of the following?

	YES	NO		YES	NO	
Pigmentation disorder	☐	☐	Skin cancer	☐	☐	_____
Accutane within 6 months	☐	☐	Photo-allergies	☐	☐	_____

What topical medications or creams are you currently using? ☐ RetinA ☐ Other (please list):

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? ☐ Yes ☐ No

Have you had any recent tanning or sun exposure that changed the color of your skin? ☐ Yes ☐ No

Have you recently used any self-tanning lotions or treatments? ☐ Yes ☐ No

Your skin type: when exposed to the sun **without protection** for about 1 hour, your skin (choose one):

- ☐ (**I**) always burns, never tans
- ☐ (**II**) always burns, sometimes tans
- ☐ (**III**) sometimes burns, sometimes tans
- ☐ (**IV**) rarely burns, always tans well
- ☐ (**V**) very rarely burns, easily tans
- ☐ (**VI**) never burns, deeply pigmented

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, aesthetician, therapist, doctor, or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatments procedures.

Patient Signature:_____ **Date:**_____

COSMETIC INTERESTS

Which of the following are you interested in?

Surgical

- ☐ **Eyelid lift / blepharoplasty**
- ☐ **Endoscopic brow lift**
- ☐ **Face / neck lift**
- ☐ **Nasal reshaping / rhinoplasty**
- ☐ **Ear reshaping / otoplasty**
- ☐ **Hair transplantation**
- ☐ **Facial Implants**
- ☐ **Fat transfer**
- ☐ **Scar Revision**
- ☐ **Other:** _____

_____

_____

Non-Surgical

- ☐ **Botox**
- ☐ **Injectibles: Restylane, Juvederm, Radiesse**
- ☐ **Laser wrinkle treatment**
- ☐ **Chemical peel**
- ☐ **IPL – photo facial**
- ☐ **Laser hair removal**
- ☐ **Laser vein removal**
- ☐ **Microdermabrasion**
- ☐ **Other:** _____

_____

_____

_____

You may also indicate the areas of concern on the diagram below: