



**HILLSTROM  
FACIAL  
PLASTIC  
SURGERY**

**941-355-3223**

**5911 North Honore Ave. Ste 120, Sarasota, FL 34243**

**Robert P. Hillstrom, M.D, FACS  
Harry V. Wright, M.D.**

American Board of Facial Plastic  
and Reconstructive Surgery  
American Board of Otolaryngology  
Head and Neck Surgery

**Patient's Name** \_\_\_\_\_

Address \_\_\_\_\_  
Last First Middle

Street & Apt # City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Any restrictions for contacting you?  Yes  No \_\_\_\_\_

E-mail \_\_\_\_\_ Would you like to receive notifications on events & specials  Yes  No

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Sex  Female  Male

Race  Caucasian  African American  Hispanic  Asian  Other \_\_\_\_\_ Language Spoken \_\_\_\_\_

Marital Status :  Single -  Domestic Partner -  Widow -  Married to: \_\_\_\_\_

**Primary Physician** \_\_\_\_\_

**Referring Physician** \_\_\_\_\_

**Preferred Pharmacy (Phone #)** \_\_\_\_\_

**Patient's Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext \_\_\_\_\_ Is it okay to call you at work?  Yes  No

Address \_\_\_\_\_

Street & Apt # City State Zip

**Emergency Contact**

Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Address \_\_\_\_\_

Street & Apt # City State Zip

**Primary Health Insurance Company** \_\_\_\_\_

**Insured Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SS#** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins Phone \_\_\_\_\_

Referral Required?  Yes  No Copay?  Yes  No \$ \_\_\_\_\_

**Secondary Health Insurance Company** \_\_\_\_\_

**Insured Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SS#** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins Phone \_\_\_\_\_

Referral Required?  Yes  No Copay?  Yes  No \$ \_\_\_\_\_

**I understand that office visit charges are payable on the day service is rendered. I authorize Hillstrom Facial Plastic Surgery to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Hillstrom Facial Plastic Surgery and myself.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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Name \_\_\_\_\_

Date \_\_\_\_\_

Thank you for choosing Hillstrom Facial Plastic Surgery. We offer a wide variety of services to help you achieve your goal of facial rejuvenation. To better serve you, please take a few moments to complete this questionnaire so that we may know your primary areas of concern and any procedures or services you may be interested in, now or in the future.

Please check all of the following areas which are of concern:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Acne scars     | <input type="checkbox"/> Jowls              | <input type="checkbox"/> Sagging neck         |
| <input type="checkbox"/> Brown spots    | <input type="checkbox"/> Lines & wrinkles   | <input type="checkbox"/> Size & shape of nose |
| <input type="checkbox"/> Double chin    | <input type="checkbox"/> Moles/skin lesions | <input type="checkbox"/> Thin & wrinkled lips |
| <input type="checkbox"/> Droopy brows   | <input type="checkbox"/> Protruding ears    | <input type="checkbox"/> Weak chin            |
| <input type="checkbox"/> Flat cheeks    | <input type="checkbox"/> Puffy eyelids      | <input type="checkbox"/> Clogged Pores        |
| <input type="checkbox"/> Uneven Texture | <input type="checkbox"/> Other              |   |

Services

The following is a list of services we provide. Please indicate which cosmetic procedures may be of interest to you.

- |  |  |
|--|--|
| <input type="checkbox"/> Aesthetic/skin care services    | <input type="checkbox"/> Skin fillers                        |
| <input type="checkbox"/> Blepharoplasty (eyelid surgery) | <input type="checkbox"/> Otoplasty (corrective ear surgery)  |
| <input type="checkbox"/> Botox                           | <input type="checkbox"/> Platysmaplasty (tightening of neck) |
| <input type="checkbox"/> Chemical Peel                   | <input type="checkbox"/> Forehead/browlift                   |
| <input type="checkbox"/> Fuller lips                     | <input type="checkbox"/> Chin augmentation                   |
| <input type="checkbox"/> Rhinoplasty (Nasal surgery)     | <input type="checkbox"/> Rhytidectomy (Face lift)            |
| <input type="checkbox"/> Facial laser resurfacing        | <input type="checkbox"/> IPL (Intense Pulsed Light)          |
| <input type="checkbox"/> Skin care products              |  |

Do you currently have a skincare specialist? \_\_\_\_\_

Please indicate which time most closely fits your schedule if you decide to proceed with surgery:

- ASAP       1-3 months       3-6 months       6-12 months

**\* A 10% deposit is required in order to hold a specific surgery date \***  
(see deposit policy)



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**Patient History Form**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

How did you first learn about Dr. Hillstrom/Dr. Wright? \_\_\_\_\_

List reason(s) for today's visit and duration of problem(s): \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Most Recent Blood Pressure: \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Past Medical History:**

**Allergies to Medication:**  No  Yes, (list medications): \_\_\_\_\_

Are you allergic to Latex?  No  Yes, (specify reaction): \_\_\_\_\_

**List Current Prescription Medications (remember to include oral meds, nasal sprays/ steroids, and topical ointments):**

1) \_\_\_\_\_ 4) \_\_\_\_\_ 7) \_\_\_\_\_ 10) \_\_\_\_\_

2) \_\_\_\_\_ 5) \_\_\_\_\_ 8) \_\_\_\_\_ 11) \_\_\_\_\_

3) \_\_\_\_\_ 6) \_\_\_\_\_ 9) \_\_\_\_\_ 12) \_\_\_\_\_

Do you take blood thinners?  No  Yes, specify name and dosage: \_\_\_\_\_

Have you ever used Accutane?  No  Yes, When was your last dose? \_\_\_\_\_

**List NON-prescription Meds:**  Aspirin \_\_\_\_\_mg;  Advil/Motrin/Nuprin (ibuprofen);  Naproxen;  Vitamin E;

Tylenol (acetaminophen);  Multivitamin;  Other Vitamins \_\_\_\_\_;  Herbals (specify) \_\_\_\_\_;

Other (specify) \_\_\_\_\_

**Please check any medical problems you have had:**  I have none of the below listed conditions and no known illnesses.

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> High blood pressure                       | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney failure    | <input type="checkbox"/> Frequent infections |
| <input type="checkbox"/> Bleeding disorder                         | <input type="checkbox"/> Thyroid problems        | <input type="checkbox"/> Lung problems     | <input type="checkbox"/> Seizures/Epilepsy   |
| <input type="checkbox"/> DVT/Blood clots                           | <input type="checkbox"/> Peptic or gastric ulcer | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Heart problems                            | <input type="checkbox"/> Reflux disease          | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Bipolar disorder    |
| <input type="checkbox"/> Stroke/TIA                                | <input type="checkbox"/> Hepatitis/HIV           | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Anxiety             |
| <input type="checkbox"/> Other(s) not listed above (specify) _____ |  |  |  |

**Hospitalizations:** (List problem(s) and year, not including surgeries) \_\_\_\_\_

**Surgeries:** (List operations and year performed including plastic surgeries) \_\_\_\_\_

Have you had LASIK surgery?  No  Yes, What was the procedure date? \_\_\_\_\_

Problems with general anesthesia?  No  Yes (specify reaction): \_\_\_\_\_

**Radiology & Imaging:** (List all CT scans or other imaging with dates) \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Social History:**

Tobacco use  Never  Cigs  Cigar  Pipe  Chew \_\_\_\_\_ packs/day for \_\_\_\_\_ years

Quit tobacco on \_\_\_\_/\_\_\_\_/\_\_\_\_

Alcohol use  Never  Wine  Beer  Shots  Mixed \_\_\_\_\_ drinks/day for \_\_\_\_\_ years

Recreational drug use  Never  Cocaine  Marijuana  Pain med  Other \_\_\_\_\_

Employment  None  Fulltime  Part time  Retired Occupation \_\_\_\_\_

Marital status (optional)  Single  Married  Divorced / Separated  Widowed

<b>Family History:</b>	<b>Diseases:</b>	<b>Family Member(s)</b>
Serious Illnesses:	<b>Cancer:</b>	

**SYSTEMS REVIEW:**  
Please check all applicable **symptoms** listed below. **Only check "None"** if no other boxes are checked in a particular category.

**General Health (Constitutional):**  Unintentional weight loss  Fever/Chills  Fatigue  None

**Eyes:**  None

Vision changes (decreased acuity, blurry, blindness)	<input type="checkbox"/> Both eyes	<input type="checkbox"/> Right eye	<input type="checkbox"/> Left eye
Double vision	<input type="checkbox"/> Both eyes	<input type="checkbox"/> Right eye	<input type="checkbox"/> Left eye
Eye pain	<input type="checkbox"/> Both eyes	<input type="checkbox"/> Right eye	<input type="checkbox"/> Left eye
Dry eyes	<input type="checkbox"/> Both eyes	<input type="checkbox"/> Right eye	<input type="checkbox"/> Left eye
Itching/burning/discharge	<input type="checkbox"/> Both eyes	<input type="checkbox"/> Right eye	<input type="checkbox"/> Left eye
Glaucoma	<input type="checkbox"/> Both eyes	<input type="checkbox"/> Right eye	<input type="checkbox"/> Left eye

**Ears, Nose, Mouth, Throat:** (problems other than reason for today's visit)  None

<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Nasal discharge or drainage	<input type="checkbox"/> Heartburn or reflux
<input type="checkbox"/> Itchy ears	<input type="checkbox"/> Nasal obstruction or blockage	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Ear pain	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Painful swallowing
<input type="checkbox"/> Ear discharge or drainage	<input type="checkbox"/> "Stuffy" nose or congestion	<input type="checkbox"/> Bleeding from throat
<input type="checkbox"/> Feeling of fluid in ears	<input type="checkbox"/> Snoring	<input type="checkbox"/> Difficulty chewing
<input type="checkbox"/> Ringing/Buzzing sound in ears	<input type="checkbox"/> Loss of sense of smell	<input type="checkbox"/> Dental, gum, or mouth pain
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Seasonal/environmental allergy	<input type="checkbox"/> Voice changes
<input type="checkbox"/> Facial weakness	<input type="checkbox"/> Breathing difficulty	<input type="checkbox"/> Pronunciation difficulty
<input type="checkbox"/> Facial pain	<input type="checkbox"/> Nosebleeds (how many? _____)	<input type="checkbox"/> Mass or lump in throat or neck
<input type="checkbox"/> Migraine or tension headaches	<input type="checkbox"/> Mass or lump in nose	<input type="checkbox"/> Other: _____

**Heart, Veins, Arteries (Cardiovascular):**  None

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Leg pain with walking	<input type="checkbox"/> Congestive heart disease
<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Leg pain at rest	<input type="checkbox"/> Mitral valve prolapse
<input type="checkbox"/> Fainting or lightheaded spells	<input type="checkbox"/> Swelling or fluid in legs	<input type="checkbox"/> Other: _____

**Lungs (Respiratory):**  None

<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Asthma or wheezing	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Cough	<input type="checkbox"/> Other: _____

**Stomach, Intestines (Gastrointestinal):**  None

<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Food intolerance
<input type="checkbox"/> Diarrhea or constipation	<input type="checkbox"/> Gastric/peptic ulcers	<input type="checkbox"/> Other: _____

**Kidney, Bladder, Genitals (Genitourinary):**  None

<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Difficulty passing urine	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Other: _____

**Bones, Joints, Muscles (Musculoskeletal):**  None

<input type="checkbox"/> Muscle weakness/fatigue	<input type="checkbox"/> Joint stiffness/pain	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Cramping	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Other: _____

**Skin (Integumentary):**  None

<input type="checkbox"/> Rash	<input type="checkbox"/> History of cold sores	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Herpes	<input type="checkbox"/> Recent baldness	<input type="checkbox"/> Other: _____

**Brain, Nerves (Neurological):**  None

<input type="checkbox"/> Paralysis	<input type="checkbox"/> Numbness or tingling	<input type="checkbox"/> Other: _____
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**Psychiatric:**  None

<input type="checkbox"/> Insomnia (trouble sleeping)	<input type="checkbox"/> Feeling anxious	<input type="checkbox"/> Eating disorders
<input type="checkbox"/> Feeling depressed	<input type="checkbox"/> Cutting/Self-inflicted injuries	<input type="checkbox"/> Other: _____

**Hormones (Endocrine):**  None

<input type="checkbox"/> Heat/cold intolerance	<input type="checkbox"/> Excessive sweating	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Excessive thirst/hunger/urination	<input type="checkbox"/> Other: _____

**Blood (Hematologic/Lymphatic):**  None

<input type="checkbox"/> Problems with blood clots	<input type="checkbox"/> Bleeding too long (will not clot)	<input type="checkbox"/> Other: _____
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**For Women only:** Are you pregnant?  Yes  No

STOP HERE. SECTION BELOW IS FOR DOCTOR USE

**Physician Review with Patient:**

## Hillstrom Facial Plastic Surgery

To ensure compliance with the Federal HIPPA Regulations (2003),

I acknowledge that I have reviewed a copy of the Hillstrom Facial Plastic Surgery's Privacy Policy.

I have been given an opportunity to read this policy and to ask questions relative to the content.

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Patient's Signature

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Date

Please specify what phone number you would like our staff to use when trying to contact you: \_\_\_\_\_



## PATIENT FINANCIAL RESPONSIBILITY FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

The physicians of Hillstrom Facial Plastic Surgery require this form to be signed by our patients. We appreciate your cooperation. If you have any questions, please ask the receptionist.

**1. FINANCIAL RESPONSIBILITY:** We are pleased to assist with your insurance. I understand that with the exceptions explained below, I am personally responsible for any medical fees I will incur with Hillstrom Facial Plastic Surgery.  
I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance to Hillstrom Facial Plastic Surgery.  
Exceptions to this policy are those patients with a current authorization with an HMO, a State or Federally funded program, or a PPO in which Hillstrom Facial Plastic Surgery, is currently a contracted provider.

**INSURANCE INFORMATION:** As a Courtesy we will bill your primary and secondary insurance carrier if you provide ALL necessary information (such as insurance cards and/or completed and signed claim forms if your carrier requires it, and their correct billing address). All co-pays are collected for each visit at the time of service.

It is ultimately my (patient's) responsibility to verify that the Physician which I am seeing is a contracted provider within my insurance network.

Signature of Patient or Legal Guardian: \_\_\_\_\_

**2. AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize Hillstrom Facial Plastic Surgery to release medical information acquired in the course of my examination or treatment, to my insurance company, or other physicians required to participate in my care.

Signature of Patient or Legal Guardian: \_\_\_\_\_

**3. AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorize payment for medical services provided directly to the Hillstrom Facial Plastic Surgery physicians.

Signature of Insured or Patient: \_\_\_\_\_

**4. PLEASE READ AND THEN CHOOSE YES OR NO:**

If you are unavailable, may we leave medical information, such as normal blood test results or normal biopsy reports on your answering machine or with someone at your residence?

\_\_\_\_\_ YES – you may leave information as above.

\_\_\_\_\_ NO – do not leave any information with anyone.

Signature of Patient or Legal Guardian: \_\_\_\_\_