

\_\_\_\_ **New Patient Data Form**    \_\_\_\_ **Updated Patient Data Form**    Acct. # \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Birth Date \_\_\_\_\_

Address: \_\_\_\_\_ may use to contact me

Name of Significant Other: \_\_\_\_\_

**Please check contact preference:**

Home telephone: \_\_\_\_/\_\_\_\_/\_\_\_\_-\_\_\_\_-\_\_\_\_

\_\_\_\_ may use to contact me

Work telephone: \_\_\_\_/\_\_\_\_/\_\_\_\_-\_\_\_\_-\_\_\_\_

\_\_\_\_ may use to contact me

Cell telephone: \_\_\_\_/\_\_\_\_/\_\_\_\_-\_\_\_\_-\_\_\_\_

\_\_\_\_ may use to contact me

E-Mail: \_\_\_\_\_

\_\_\_\_ may use to contact me

**Reason for visit/consultation:**

**Other Patient Interests. Please circle all that apply.**

**Facial Services:**

Face/Neck Lift  
 Eyebrow/Forehead Lift  
 Blepharoplasty (Eyelid Lift)  
 UltraPulse Laser Resurfacing  
 Nose Reshaping  
 Cheek/Chin Reshaping  
 Lip Enhancement  
 Ear Reshaping  
 Fat Injection – Filler  
 Face fillers-Juvéderm™  
 Restylane/Radiesse/Belotero\*  
 Sculptra  
 Botox® Cosmetic/Xeomin\*  
 Scar Revision

**Body Contouring Services:**

Breast Augmentation (Breast Enlargement)  
 Breast Lift  
 Liposuction Fat Removal  
 Abdominoplasty (Tummy Tuck)  
 Lipoabdominoplasty  
 Brachioplasty (Arm Lift)  
 Inverted Nipple Correction  
 Gynecomastia (Male Breast Reduction)  
 Labiaplasty  
 Thigh Lift  
 Thigh/Buttock Lift  
 Tattoo Removal (by excision)

**Facial/Body Services-Non-Surgical**

Laser Hair Removal  
 Skin Care-Daily/Aging/Wrinkling  
 Anti-aging Treatments, Face Peels  
 Microdermabrasion  
 Rosacea  
 Preventing/Reversing Sun Damage  
 Age/Sun Spots, Hyperpigmentation  
 Facial Capillary Removal  
 Leg Spider Veins  
 Massage/Reflexology  
 Cellulite Reduction/Endermologie/Lipomassage™  
 truSculpt™ Body Shaping & Fat Reduction  
 Ultherapy® Facial Skin Lifting  
 Latisse® Eyelash Enhancement

\*Non-surgical treatment administered by Board Certified plastic and cosmetic surgeon

Who or what referred you to our practice? \_\_\_\_\_

Have you seen our: Website \_\_\_\_ Yellow Pages ads \_\_\_\_ Newspaper ads \_\_\_\_ Television ads \_\_\_\_  
 (check all that apply)

Where else have you heard about or obtained information on our practice? \_\_\_\_\_

Have you received mailings from us? \_\_\_\_ Yes \_\_\_\_ No

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Steven Yarinsky will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

I acknowledge that the above information is complete and accurate, and has been provided to Saratoga Springs Plastic Surgery, P.C. for the exclusive use of the practice in serving my interests and desire for treatment by Saratoga Springs Plastic Surgery, P.C. I reserve the right to provide updated information to the practice. The practice may periodically request that I update my patient information. The above information including general health history is only for initial discovery; additional information may be requested to qualify or disqualify me as a candidate for a certain procedure(s).

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



7 Wells Street , Suite 303  
Saratoga Springs, NY 12866  
Phone: (518) 583-4019 Fax: (518) 583-3350  
www.yarinsky.com

## MEDICAL INFORMATION

Please bring on appointment date - Please print

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Social Security No. \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
Employer Phone: \_\_\_\_\_

For your benefit it is necessary that you answer these questions as accurately as possible so that we can determine your physical condition before undergoing surgery.

1. DO YOU HAVE: YES NO  
Heart disease \_\_\_\_\_  
High blood pressure \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Epilepsy \_\_\_\_\_  
Thyroid disease \_\_\_\_\_  
Asthma \_\_\_\_\_

2. HAVE YOU EVER HAD: YES NO  
Rheumatic fever \_\_\_\_\_

3. DO YOU HAVE: YES NO  
Shortness of breath \_\_\_\_\_  
Dizzy spells \_\_\_\_\_  
Swelling of ankles \_\_\_\_\_  
Chest pain \_\_\_\_\_  
Prolonged bleeding \_\_\_\_\_  
Jaundice \_\_\_\_\_  
Bruise easily \_\_\_\_\_  
History of herpes/  
cold sores \_\_\_\_\_  
MRSA \_\_\_\_\_  
(staph infection) \_\_\_\_\_

4. DO YOU TAKE: YES NO  
Blood thinner meds \_\_\_\_\_  
Heart medication \_\_\_\_\_  
High blood pressure  
meds \_\_\_\_\_  
Diuretic (water pill) \_\_\_\_\_  
Aspirin \_\_\_\_\_  
Diet pills \_\_\_\_\_

5. DO YOU TAKE OR HAVE YOU EVER  
TAKEN STEROIDS (CORTISONE, ETC): YES NO  
\_\_\_\_\_

6. ARE YOU ALLERGIC TO: YES NO  
Penicillin \_\_\_\_\_  
Local anesthetic \_\_\_\_\_  
Other drugs (please list) \_\_\_\_\_

7. LIST OPERATIONS YOU HAVE HAD AND ANY COMPLICATIONS:  
\_\_\_\_\_  
Date \_\_\_\_\_  
\_\_\_\_\_  
Date \_\_\_\_\_  
\_\_\_\_\_  
Date \_\_\_\_\_  
\_\_\_\_\_  
Date \_\_\_\_\_

8. LIST MEDICATIONS YOU TAKE:  
(include dosage)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. PLEASE LIST ANY UNUSUAL MEDICAL PROBLEMS:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. NUMBER OF PREGNANCIES \_\_\_\_\_  
Children – Age \_\_\_\_\_ Sex \_\_\_\_\_

11. DO YOU SMOKE? YES NO  
\_\_\_\_\_  
\_\_\_\_\_  
Number of packs per day \_\_\_\_\_

12. DO YOU DRINK ALCOHOL YES NO  
\_\_\_\_\_  
\_\_\_\_\_  
Socially \_\_\_\_\_ Monthly \_\_\_\_\_ Weekly \_\_\_\_\_ Daily \_\_\_\_\_

13. HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

14. DO YOU FEEL SAFE IN YOUR HOME ENVIRONMENT? YES NO  
\_\_\_\_\_  
\_\_\_\_\_

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## Involvement in Care Consent Form

**Patient Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zipcode** \_\_\_\_\_

I hereby request that the following person(s) be allowed to participate in my care or payment-decision process. I understand that these person(s) may be given verbal or written health care or payment information about me at their request or if I am unavailable or unable to communicate. Saratoga Springs Plastic Surgery, PC will act on this information until I revoke or amend this authorization in writing.

**Note:** In the event this person is to be involved in healthcare decisions for you, a healthcare proxy must be completed in accordance with the related policy.

Name	Relationship	Date of Birth	Phone Number	Type of Information to be Released

Saratoga Springs Plastic Surgery, PC will make a reasonable effort to provide only the necessary information for the person(s) listed to make an informed decision, to assist with your care, or to receive printed protected health information.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_

**Witness Printed Name:** \_\_\_\_\_

**Notary:**

Notarized signature is required only if form is not signed and witnessed in person at Saratoga Springs Plastic Surgery, PC.

Cancellation Policy  
March 20, 2015

To: All Patients

From: Saratoga Springs Plastic Surgery, PC

To cancel and/or reschedule your appointment, we require at least 48 hour notice (2 business day). Monday appointments must be cancelled by Wednesday at 4 p.m.

If you fail to show for your appointment or do not give at least the advance notice listed above, you will lose a treatment in your prepaid package. If you are scheduled for an individual treatment which is not prepaid, you will be billed \$100 for the missed appointment.

Missed complimentary treatments will not be rescheduled at no charge.

Patient:

I have read, understand and have received a copy of Saratoga Springs Plastic Surgery, P.C.'s Appointment Cancellation Policy.

Patient Signature: \_\_\_\_\_ Date:\_\_\_\_\_

\_\_\_\_\_  
Patient's Printed Name

Witness Signature: \_\_\_\_\_ Date:\_\_\_\_\_

\_\_\_\_\_  
Witness' Printed Name

**DIRECTIONS TO SARATOGA SPRINGS PLASTIC SURGERY  
7 WELLS STREET  
SARATOGA SPRINGS, NEW YORK 12866**

**From Points South:** Take I-87 (Northway) to Exit 15. Take a left onto Rte. 50. Get in the right hand lane and follow Rte. 50 South until you come to the intersection of Broadway.

At this intersection you'll see the Saratoga Hilton (former Saratoga Hotel) on the your left. Cross over Broadway onto Van Dam Street. Go up Van Dam (a small hill) and go to first red light. From this light continue four blocks and make a right onto Wells Street, go to 7 Wells Street.

We are in the brick Professional building on your left; this is the corner of Wells & Waterbury. Straight ahead are two parking lots, park in either. Go in main entrance and take elevator to the third floor. Our office will be directly in front of you when you exit the elevator.

**From Points North:** Take I-87 (Northway) to Exit 15. Take a right onto Rte. 50. Get in the right hand lane and follow Rte. 50 South. Follow above directions.

**For more information about food, lodging  
and activities in Saratoga Springs, visit  
[www.saratoga.org](http://www.saratoga.org)**

