ANTHONY E. BRISSETT, M.D., FACS

Houston Methodist Facial Plastic Surgery

6550 Fannin St., Suite 1703 • Houston, Texas 77030

PATIENT INFORMATION

NAME (LAST) (FIRST) (MIDDLE) PREFERRED/NICKNAME

SEX: M F DOB: / / SOCIAL SECURITY #: - -

MAILING ADDRESS: (STREET) (CITY) (STATE) (ZIP)

PERMANENT ADDRESS-
IF DIFFERENT: (STREET) (CITY) (STATE) (ZIP)

HOME PHONE: WORK PHONE: CELL/PAGER:

DRIVER'S LICENSE #: EMAIL ADDRESS:

OCCUPATION: EMPLOYER:

EMPLOYER ADDRESS:

WHY ARE YOU BEING SEEN? **HOW DID YOU HEAR ABOUT US**

HOW LONG HAVE YOU HAD THIS PROBLEM? OTHER DOCTORS SEEN FOR PROBLEM:

IS A REFERRAL NEEDED BY YOUR INSURANCE? Y N HAS ONE BEEN OBTAINED? Y N

****IF OUR DOCTOR IS NOT IN NETWORK-YOU WILL BE RESPONSIBLE FOR OUT-OF-NETWORK PROCESSING****

PRIMARY CARE PHYSICIAN – FIRST & LAST NAME, ADDRESS & PHONE#:

REFERRED BY – PHYSICIAN'S FIRST, LAST NAME, ADDRESS & PHONE #:

PHARMACY NAME: PHONE #:

PERSON TO NOTIFY IN CASE OF EMERGENCY (FULL NAME, RELATIONSHIP & PHONE#):

PREFERRED WRITTEN AND SPOKEN LANGUAGE:_____

RACE: ☐ **AFRICIAN AMERICAN** ☐ **ASIAN** ☐ **ASIAN-INDIAN** ☐ **CAUCASIAN** ☐ **MIDDLE EASTERN AMERICAN** ☐ **NATIVE AMERICAN** ☐ **PACIFIC ISLANDER** ☐ **OTHER, or** ☐ **DECLINE**

ETHNICITY: ☐ **HISPANIC OR LATINO** ☐ **NON-HISPANIC OR LATINO** ☐ **DECLINE**

MARITAL STATUS: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

HOUSTON Methodist SPECIALTY PHYSICIAN GROUP

PAST HISTORY - GIVE NAMES & DATES

PREVIOUS SURGERY/HOSPITALIZATIONS

MAJOR ILLNESSES/INJURIES:

ALLERGIES TO MEDICATIONS: (IF NONE, PLEASE WRITE NONE)

HISTORY OF OR ARE YOU CURRENTLY HAVING PROBLEMS WITH:	(Y)	(N)	ANY FAMILY MEMBERS:	(Y)	(N)	PRESENT WEIGHT:
DIABETES	Y	N	DIABETES	Y	N	
ALLERGIES	Y	N	ALLERGIES	Y	N	HEIGHT:
HEART DISEASE	Y	N	HEART DISEASE	Y	N	AGE:
HIGH BLOOD PRESSURE	Y	N	HIGH BLOOD PRESSURE	Y	N	
STROKE/EPILEPSY/CONVULSIONS	Y	N	STROKE	Y	N	DO YOU SMOKE? (Y) (N)
CANCER/TUMOR/GROWTH	Y	N	CANCER/TUMOR	Y	N	HOW LONG?
TUBERCULOSIS	Y	N	TUBERCULOSIS	Y	N	HOW MUCH?
ULCER/STOMACH PROBLEMS	Y	N	ULCER	Y	N	ARE YOU PREGNANT?
INJURY TO HEAD OR NECK	Y	N	HEARING LOSS	Y	N	HIV/AIDS? ____Yes _____No
HEPATITIS/LIVER DISEASE	Y	N	ARTHRITIS	Y	N	CURRENT MEDICATIONS:
KIDNEY/BLADDER INFECTIONS	Y	N	THYROID TROUBLE	Y	N	
TENDENCY TO EASILY BLEED	Y	N	TENDENCY TO BLEED EASILY	Y	N	OTHER:
ANTIBIOTICS BY INJECTIONS FOR MORE THAN ONE WEEK	Y	N		Y	N	
HEARING LOSS	Y	N	HEARING LOSS	Y	N	
SKIN DISORDERS	Y	N	SKIN DISORDERS	Y	N	
PSYCHIATRIC DISORDERS	Y	N	PSYCHIATRIC DISORDERS	Y	N	
NONE □	Y	N	NONE □			

FINANCIALLY RESPONSIBLE PARTY INFORMATION

NAME:(LAST) (FIRST) (MIDDLE)

SEX: M F DOB: / / SOCIAL SECURITY #: - -

MAILING ADDRESS: (STREET) (CITY) (STATE) (ZIP)

HOME ADDRESS-

IF DIFFERENT: (STREET) (CITY) (STATE) (ZIP)

INSURANCE INFORMATION

MEDICARE: Y N PRIMARY OR SECONDARY: TRADITIONAL OR HMO (CIRCLE ALL THAT APPLY)

NAME ON CARD:

MEDICAID: Y N TRADITIONAL OR HMO OTHER COVERAGE Y N (CIRCLE ALL THAT APPLY)

MEDICAID #: HMO PLAN NAME:

PCP (FULL NAME, ADDRESS & PHONE#):

PRIMARY INSURANCE NAME: PHONE#:

FOR THE POLICY HOLDER

FULL NAME: D.O.B: / / SOCIAL SECURITY#: - -

POLICY #: GROUP#: NETWORK NAME:

SECONDARY INSURANCE NAME: PHONE#:

FOR THE POLICY HOLDER

FULL NAME: D.O.B: / / SOCIAL SECURITY#:

POLICY#: GROUP #: NETWORK NAME:

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Office: 713-441-FACE (3223) * Fax: 713-796-9096

Patient Photography Consent

Patient Name _____ **DOB:** _____
(PRINT)

I consent to the taking of photographs by Dr. Anthony E. Brissett or his designee of me in connection with the procedure(s) to be performed. I hereby also grant permission for the use of my medical records including illustrations, photographs, or other imaging records created in my case, for us in examination, testing, credentialing and/or certifying purposes by Houston Methodist Facial Plastic Surgery Associates.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of Dr. Anthony E. Brissett and may be retained or released by Dr. Anthony E. Brissett for the purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, Web sites, patient demonstration purposes for the purpose of information the medical profession, the general public, and prospective patients about plastic surgery procedures. I understand the photographs may portray features that will make my identity recognizable.

I understand I may refuse to authorize release of any health information, but will not affect the health care services I receive. I understand I may inspect and copy the information that I have authorized to be disclosed and to revoke this authorization in writing at any time. I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). I further understand that, because Dr. Anthony E. Brissett is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPPA.

I release and discharge Dr. Anthony E. Brissett, Houston Methodist Facial Plastic Surgery Associates, and all parties acting under their license and authority from all rights and claims that I may have in the photographs and relating to such use in publication, including any claim for payment in connection with distribution or publication of photographs.

I understand that the doctor-patient relationship is a bond of trust and mutual respect that ethically and legally precludes Dr. Brissett from disclosing information about me without my permission. Therefore, I too, agree not to disclose any information regarding the care I received from him without permission. If a Patient does prepare commentary for publication about the Doctor, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to the Doctor for any written, pictorial, and/or electronic commentary. Patient and Doctor acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Doctor agree to the right of equitable relief (including but not limited to injunctive relief). Houston Methodist Facial Plastic Surgery Associates collects email addresses for marketing purposes. We may use your email to extend special offers by us for third parties.

I certify that I have the above Authorization and Release and internet posting policy and fully understand its terms.

Signature _____ Date _____

Exceptions (i.e., medical records only) _____
I have read the above consent. I am the parent, guardian, or conservator of _____, a minor.
I am authorized to sign this authorization on his/her behalf and give this authorization.
Signature _____ Date _____

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