THE LANGSDON CLINIC

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(901) 755-6465

Consultation and Medical Questionnaire

Name ______________________ Date of Birth __________ Today's Date __________
Home Address: Street ______________________ City ______________________
State __________ Zip __________ Home Phone ______________________
Work ______________________
Cell __________ Email ______________________
Marital Status: ☐ S ☐ M ☐ D ☐ Sep Occupation __________ Ages of Children __________
Emergency Contact: ______________________ Relationship __________
Work Phone __________ Home Phone __________
How were you referred to us? ______________________
Names of family members who are our patients ______________________
In which procedure(s) are you interested? (please check each applicable block)

☐ Rhinoplasty (nose)	☐ Chin	☐ Face or neck lift	☐ Eyelids
☐ Chemical peel/Dermabrasion	☐ Scar revision	☐ Protruding ears	☐ Non-surgical Fillers
☐ Hair Transplant	☐ Day Lift	☐ Laser procedures	☐ Other

What specifically do you wish to have corrected? (i.e. what don't you like about the above condition(s)?)
____
Do you desire improvement in both appearance and function? ☐ Yes ☐ No
When did you begin to consider surgical correction? ______________________
Why have you decided to have it done at this point in time? ______________________
Have you consulted any other doctor about this? (when?) ______________________
Have you discussed this surgery with your family? ☐ Yes ☐ No
Have you had any other surgery, or an injury, to the face, nose, neck or eyes? ☐ Yes ☐ No
When? __________ Describe, what was done ______________________
Who performed the surgery? __________ Where was it performed? __________
Were you satisfied with the results? ☐ Yes ☐ No If not, why? __________
Has anyone in your family or a close friend had cosmetic or reconstructive surgery? ☐ Yes ☐ No
What was done? __________ By whom? __________
Have you had any other surgery? ☐ Yes ☐ No What was done and when was it performed?

☐ In the head and neck area? __________	☐ On your skin? __________
☐ On your teeth or gums? __________	☐ In your chest? __________
☐ In your abdomen? __________	☐ On the reproductive system? __________
☐ On your back, arms or legs? __________	☐ Other __________

Were there any complications? Did you have a normal recovery ☐ Yes ☐ No
Were you satisfied with the results? ☐ Yes ☐ No If not, why? __________

MEDICAL HISTORY (check the appropriate responses)

☐ Yes ☐ No Are you now taking any drugs, medications, diet aids, or vitamins? How often? __________
List them, please ______________________
☐ Yes ☐ No Are you allergic to any medications? ______________________
List them, please ______________________
☐ Yes ☐ No Are you allergic to latex? Describe ______________________
When was your last physical examination? __________ Who is your family doctor? __________
Doctor's address ______________________ Phone number __________
☐ Yes ☐ No Would you object to our contacting him/her in regard to any medical problem that might arise?
☐ Yes ☐ No Have you ever received local anesthesia ("Novocaine or Xylocaine") by a dentist or physician?
☐ Yes ☐ No Did you have any "reaction" to any anesthetic? Explain

(continued on back)

MEDICAL HISTORY (continued)

❒ Yes ❒ No **Are you considered a healthy person?**

Do you or any family member have: (check applicable block(s) and note family member)

❒ Heart trouble ______________ ❒ Excessive bleeding tendencies ______________
❒ Psychiatric or "nerve" problems ______________ ❒ High blood pressure ______________
❒ Diabetes ______________ ❒ Thyroid problems ______________
❒ Excessive bruisability ______________ ❒ Excessive scarring ______________

Do you have a history of bleeding: (indicate which)

❒ From the nose ❒ In the urine ❒ Vomiting blood ❒ From the rectum
❒ Coughing up blood ❒ Other ______________

❒ Yes ❒ No Do you have hay fever, nasal allergies or asthma? Explain? ______________
❒ Yes ❒ No Do you have or have you had any problems with your eyes or vision? Explain ______________
❒ Yes ❒ No Do you have frequent pains in your chest? Explain ______________
❒ Yes ❒ No Has your doctor ever said you had "heart trouble"? Explain ______________
❒ Yes ❒ No Do you have "stomach trouble" or ulcers? Explain ______________
❒ Yes ❒ No Do you have or have you had chest or lung problems? Explain ______________
❒ Yes ❒ No Have you ever had liver, gall bladder trouble or "yellow jaundice"? (Circle which one.)
❒ Yes ❒ No Have you been bothered by kidney or bladder problems? Explain ______________
❒ Yes ❒ No Do you or any family members suffer from "arthritis"? Explain ______________
❒ Yes ❒ No Do you have frequent skin infections, irritations, or rashes? (Circle which one.)
❒ Yes ❒ No Do you often have severe headaches or dizzy spells? (Circle which one.)
❒ Yes ❒ No Has any part of your body ever been paralyzed or numb? Explain ______________
❒ Yes ❒ No Have you ever had a convulsion or seizure? Explain ______________
❒ Yes ❒ No Have you ever received treatment for your genital area? Explain ______________
❒ Yes ❒ No Have you ever been treated for any venereal disease? Explain ______________
❒ Yes ❒ No Are your frequently sick or ill?
❒ Yes ❒ No Do you worry about your health?
❒ Yes ❒ No Were you ever treated for anemia or any problems with your blood? Explain ______________
❒ Yes ❒ No Have you ever taken hormones or thyroid medication? Explain ______________
❒ Yes ❒ No Do you smoke? How may cigarettes per day?______
❒ Yes ❒ No Do you drink more than 6 cups of coffee a day?
❒ Yes ❒ No Do you usually take two or more alcoholic drinks a day?
❒ Yes ❒ No Have you ever received treatment for abuse of alcohol or drugs? Explain ______________
❒ Yes ❒ No Do you often get depressed?
❒ Yes ❒ No Do you usually feel unhappy or depressed?
❒ Yes ❒ No Are you considered a nervous person?
❒ Yes ❒ No Have you ever had a "nervous breakdown"? Explain ______________
❒ Yes ❒ No Are you easily upset or irritated?
❒ Yes ❒ No Do you tend to hold a "grudge" when someone angers you?
❒ Yes ❒ No Have you ever considered consulting a psychiatrist or psychologist? Explain ______________
❒ Yes ❒ No Have you ever been under the care of a psychiatrist or psychologist? Explain ______________

WOMEN ONLY: When was your last menstrual period? ______________
❒ Yes ❒ No Are your periods often irregular?
❒ Yes ❒ No Have you had "female" or GYN problems? Explain ______________

MEN ONLY: ❒ Yes ❒ No Have you ever had prostate problems? Explain ______________

MEN AND WOMEN:

❒ Yes ❒ No Do you accept the fact that every medical and surgical treatment is associated with risks and other imponderables?
❒ Yes ❒ No Do you have any other medical problems that have not been covered? Explain ______________

Signature ______________________ Date ______________

The Langsdon Clinic
EVALUATION and INJECTION QUESTIONNAIRE

Your Name____ Date____________________________

Are you worried about how you look? Examples of areas of concern include: skin (for example; scars, wrinkles, redness), the shape of your nose, mouth jaw or lips: Please list specific areas____
____.

Do you deliberately check your features in the mirror multiple times each day? Yes / No

Do you avoid mirrors, photos, or videos of yourself? Yes / No

Do you feel like your features are unattractive? Yes / No

Do your features cause you a lot of distress? Yes / No

Do your features cause you to avoid situations or activities? Yes / No

Do your features preoccupy your thoughts? Yes / No

Do your features have an effect on your relationships? Yes / No

Do your features interfere with your social life? Yes / No

Do you feel your appearance is the most important aspect of who you are? Yes / No

Please fill out the following information regarding previous Botox, and/or dermal filler injections **not received at this clinic:**

What product(s) were injected?____

What area(s) of the face were injected?____

Who administered the injection(s)?____

Dates of the Injection(s):____

Did you have any adverse reaction or side effects?____

If so, please explain____

Were you satisfied with the results?____

If not, please explain____

The Langsdon Clinic

EYE EVALUATION SHEET

Your Name________________________________ Date____________________

Your "Eye Doctor's" Name____

Your "Eye Doctor's" Address____

Date of last exam or visit________________________________

YES	NO	
_____	_____	At your last examination were you told you have any problems with your eyes? Explain________________________________
_____	_____	Do you require glasses or contact lenses?
_____	_____	Have you had any injuries or surgery to the eyes or lids? (By Whom?________________) Explain________________________________
_____	_____	Are you bothered by frequent irritations or "allergies" of the eyes or lids?
_____	_____	Do you feel your eyes or lids swell excessively?
_____	_____	Do you now take or have you ever taken medications or drops for the eyes? Explain________________________________
_____	_____	Are you bothered by "dry eyes"?
_____	_____	Do your eyes "water" or tear spontaneously (without emotional stimulation)?
_____	_____	Do you now have or have you ever had any visual problems with one or both eyes? Explain________________________________
_____	_____	Are there any other problems we have not asked about that you feel we should know? Explain________________________________

PLEASE READ THE FOLLOWING AND CARRY OUT THE INSTRUCTIONS:

Cover your RIGHT eye and read THIS sentence with your LEFT eye.
Are you able to read it comfortably?
____without glasses ____with glasses

Cover your LEFT eye and read THIS sentence with your RIGHT eye.
Are you able to read it comfortably?
____without glasses ____with glasses

If there is any difference in your vision please indicate:
___Right eye stronger ____Left eye stronger ____Both eyes same(approximately)

I signify that to the best of my knowledge the information provided above is accurate.

Signature________________________________ Date____________________

The Langsdon Clinic

7499 Poplar Pike
Germantown, TN 38138

REGISTRATION FORM / PRIVACY NOTICE SIGNATURE

____ ____________________
Patient Name **Date of Birth**

__________________________ __________________________ __________________________
Employer Name **Occupation** **Employer Phone Number**

A. PATIENT RESPONSIBILITIES: I understand that as a patient, parent or guardian, I am legally responsible for payments of all charges relating to my care. Patient and/or guarantor(s) agree to pay reasonable attorney fees and cost of collection if patient's account is placed in the hands of a collection agency or an attorney for collecting. As a general rule, The Langsdon Clinic does not file insurance. Services provided are cosmetic in nature and are not billable to insurance. Dr. Langsdon is not currently a provider for Medicare.

B. (By providing your email and mailing address, you are giving us permission to send emails and mail regarding promotions, specials, etc. Most of our practice discounts are sent via email)

I am giving permission to contact me by the following listings:
______________________________Email
______________________________Cell Phone (Are we allowed to leave a voice mail message? Circle Y or N)
______________________________Home Phone (Are we allowed to leave a voice mail message? Circle Y or N)

C. I hereby give permission for the following individuals to have access to any medical/financial information regarding my care:
1. ______________________________ Relationship to patient______________________
2. ______________________________ Relationship to patient______________________

D. I have read the Privacy Notice and understand my rights contained in the notice. If insurance is filed, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act, or under other insurance coverage, is correct. I authorize any holder of medical or other information about me to release to S.S.A. or its intermediaries or carriers and/or the State in which I reside or Fiscal Agents, or the insurance company or its representatives, any information needed for any insurance claim. In consideration of services rendered, I transfer and assign to Phillip R. Langsdon, MD, any payment which may become due to me for medical and/or surgical services under policies applicable to me or my dependent. By way of my signature, I provide The Langsdon Clinic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

______________________________________ ______________________________
Patient's OR Guarantor Signature Date

The Langsdon Clinic
Please keep for your records

NOTICE OF PRIVACY PRACTICES

This Notice describes how medial information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for medical information, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care. Payment: We may use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and service that may be of interest to you.

Other Uses and Disclosures
We may use or disclose your health information for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

- *Required by Law:* We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- *Public Health Activities:* As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information about you to public health authorities.
- *Health Oversight:* We may be required to disclose your health information to assist in investigations and audits, eligibility for government programs, and similar activities.
- *Judicial and Administrative Proceedings:* We may disclose your health information in response to an appropriate subpoena, discovery request, or court order
- *Law Enforcement Purposes:* Subject to certain restrictions, we may disclose information required by law enforcement officials.
- *Deaths:* We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
- *Serious Threat to Health or Safety:* We may use and disclose your health information when necessary to or prevent a serious threat to your health and safety or the health and safety of the public or another person.
- *Military and Special Government Functions:* If you are a member of the armed forces, we may release your health information as required by military command authorities. We may also disclose information about you to correctional institutions or for national security purposes.
- *Research:* We may use or disclose your health information for approved medical research.
- *Workers Compensation:* We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

You have the right and choice to tell us to share your information with your family, close friends, or others involved in your care or share your information in a disaster relief situation. If you are not able to tell us your preference, for instance, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to

health or safety. Unless you give us written permission, we will not share your information for marketing purposes of sell your information.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the rights with regard to your health information. If you have given someone health care decision making rights for you or if someone is your health guardian, that person can exercise your rights and make choices about your health information. Please contact the person listed below to obtain
the appropriate form for exercising these rights.
Request Restriction: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. However, if you pay for a service in full out-of-pocket, you can request that we not share that information with your health insurer and we will agree to such a request, unless we are required to disclose the information by law.
Confidential Communications: You may ask us to communicate with your confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information within ten (10) business days of making such a request. There may be a small charge for the copies. You may also request that your records be provided to you in electronic form.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information. We may not agree to your request but we will provide you with a response in writing within sixty (60) days of your request.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you in the past six (6) years for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to notify you following a breach of your unsecured heath information, to provide provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Change in Privacy Practices
We may change our policies at any time and those changes will apply to your health information we have previously received and new health information we may receive from you in the future. Before we make a significant change in our policies, we will change our Notice and post the new Notice on our website, in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:
Name: Vicki Almond
Title: Clinic Manager
Address: 7499 Poplar Pike
Germantown, TN 38138
Phone: 901-755-6465

Effective Date:
The effective date of this Notice is 2/8/18.