



*The Stella Center*  
FACIAL PLASTIC SURGERY

*Thank you for considering Dr. Stella Desyatnikova and The Stella Center for your cosmetic and surgical needs. With over six years of experience and two board certifications including Facial Plastic Surgery, Dr. Stella utilizes the skill, education and technique to make your time with us an experience above the rest. Once again we would like to thank you for joining us at The Stella Center!*

*We know you will be more than satisfied with your experience and our service.*

Your Name: \_\_\_\_\_

Please let us know how you were referred to us:

*~ please check all that apply ~*

Internet:

- |                                               |                                                             |
|-----------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Google.com search    | <input type="checkbox"/> Citysearch.com                     |
| <input type="checkbox"/> Google advertisement | <input type="checkbox"/> Yahoo.com                          |
| <input type="checkbox"/> Realself.com         | <input type="checkbox"/> Bing.com                           |
| <input type="checkbox"/> Doctorstella.com     | <input type="checkbox"/> King 5: Best of Western Washington |

Friends of The Stella Center:

- |                                                      |                                                            |
|------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Dress for Success           | <input type="checkbox"/> Pasado's Safe Haven               |
| <input type="checkbox"/> The Gilt Edge Society Salon | <input type="checkbox"/> Aesthetic Laser Center of Seattle |

Magazine:

- |                                           |                                               |
|-------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Seattle Magazine | <input type="checkbox"/> Seattle Metropolitan |
| <input type="checkbox"/> Perspective      | <input type="checkbox"/> Other: _____         |

Other:

- |                                                                      |                                                 |
|----------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Friend's Name: _____                        | <input type="checkbox"/> Relative's Name: _____ |
| <input type="checkbox"/> Physician's Name: _____                     |                                                 |
| <input type="checkbox"/> Current Patient of The Stella Center: _____ |                                                 |
| <input type="checkbox"/> Newspaper: _____                            |                                                 |

**THE STELLA CENTER**  
509 Olive Way, Suite 1430  
Seattle, WA 98101

**PATIENT REGISTRATION INFORMATION**

Date: \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_  
Last Name First Name Initial

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

In case of emergency, who should we contact? \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_ Address: \_\_\_\_\_

Name of Primary Care Physician/Primary Care Facility: \_\_\_\_\_

May we remind you about upcoming or missed appointments?  
 Yes  No

Preferred contact phone# (\_\_\_\_\_) \_\_\_\_\_

Preferred contact e-mail address: \_\_\_\_\_

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

If so, how would you like to receive them? (Check one or both)  
 Email  
 Regular Mail

**BILLING INFORMATION – Only for Insurance Related Visits**

Insurance Subscriber: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
(If other than patient)

Address: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Do you have Medicare?  Yes  No

Are you seeking care in relation to an accident?  Yes  No

Medicare ID#: \_\_\_\_\_

As a result of work?  Yes  No

Primary Insurance Company: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_ Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I hereby authorize payment directly to The Stella Center 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: \_\_\_\_\_

**PRIVACY POLICY**

I hereby acknowledge that I have received a copy of the *Notice of Privacy Practices* form: \_\_\_\_\_ (Please Print Initials)

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SEATTLE, WA 98101

Height \_\_\_\_\_

Weight \_\_\_\_\_

Age \_\_\_\_\_

## HEALTH QUESTIONNAIRE

### PATIENT MEDICAL HISTORY

Have you had any Serious Injuries / Illnesses / Medical Problems? *(Please describe and give dates)*

Date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been Hospitalized or had Surgery? *(Please describe and give dates)*

Date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any current Medications and Vitamins you are currently taking: *(Please also list dosage and frequency of use)*

\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any drugs or medications? If so, please explain: \_\_\_\_\_

Last date of Immunizations: Flu \_\_\_/\_\_\_/\_\_\_ Tetanus \_\_\_/\_\_\_/\_\_\_ Pneumovax \_\_\_/\_\_\_/\_\_\_

Do you take aspirin or anticoagulants?  Yes  No

### PATIENT SOCIAL HISTORY

Sex:  M  F Marital Status:  Single  Married  Divorced  Widowed  Long-Term Partner  Separated

Use of Alcohol:  Never  Rarely  Moderate  Daily *(Specify Details):* \_\_\_\_\_

Use of Caffeine:  Coffee  Sodas  Tea *(Cups per Day):* \_\_\_\_\_

Use of Tobacco:  Never  Previously, but Quit  Currently *(Packs per Day):* \_\_\_\_\_

Exercise:  Never  Rarely  Weekly  Daily *(Type of Exercise):* \_\_\_\_\_

Do you currently use:    Eyeglasses     Yes  No                      Contact lenses     Yes  No  
                                         Hearing aid(s)     Yes  No                      Dentures             Yes  No

Are you pregnant or is it possible that you may be pregnant?  Yes  No

Are you currently taking birth control?  Yes  No    If so, what type? \_\_\_\_\_

### FAMILY MEDICAL HISTORY – Do you know of any blood relative who have or had any of the following? *(Indicate Relationship)*

Arthritis \_\_\_\_\_  
 Asthma/Allergies \_\_\_\_\_  
 Bleeding Tendency \_\_\_\_\_  
 Cancer \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Genetic Disorder \_\_\_\_\_  
 Heart Disease \_\_\_\_\_

High Blood Pressure \_\_\_\_\_  
 Mental Illness \_\_\_\_\_  
 Reaction to Anesthesia \_\_\_\_\_  
 Stroke \_\_\_\_\_  
 Tuberculosis \_\_\_\_\_  
 DVT, Blood Clot \_\_\_\_\_  
 Pulmonary Embolism \_\_\_\_\_

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

**ARE YOU EXPERIENCING OR HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING:**

**CONSTITUTIONAL SYMPTOMS**

Unexplained weight gain or loss..... Yes No  
 Fever or chills..... Yes No  
 Night sweats/Hot flashes..... Yes No  
 Fatigue..... Yes No

**HEMATOLOGIC/LYMPHATIC**

Bleeding or bruising tendency..... Yes No  
 Anemia..... Yes No

**EYES**

Blurred or double vision..... Yes No

**EARS/NOSE/MOUTH/THROAT**

Hearing loss or ringing..... Yes No  
 Earaches or drainage..... Yes No  
 Chronic sinus problem or rhinitis..... Yes No  
 Recurrent nose bleeds..... Yes No  
 Bleeding gums..... Yes No  
 Sore throat or voice change (hoarseness)..... Yes No  
 Hay fever..... Yes No

**CARDIOVASCULAR**

Heart trouble..... Yes No  
 Chest pain or angina pectoris..... Yes No  
 Palpitation (fast or irregular heart beat)..... Yes No  
 Shortness of breath while walking or lying flat ..... Yes No  
 Swelling of feet, ankles or hands..... Yes No  
 High blood pressure..... Yes No  
 DVT, blood clot or pulmonary embolism..... Yes No  
 Have you ever been on IV antibiotics?..... Yes No

**RESPIRATORY**

Chronic or frequent coughs..... Yes No  
 Spitting up blood..... Yes No  
 Shortness of breath..... Yes No  
 Asthma or wheezing..... Yes No

**GASTROINTESTINAL**

Loss of appetite..... Yes No  
 Change in bowel movement..... Yes No  
 Nausea or vomiting..... Yes No  
 Frequent Diarrhea..... Yes No  
 Painful bowel movement or constipation..... Yes No  
 Rectal bleeding or blood in stool..... Yes No  
 Abdominal pain or heartburn..... Yes No  
 Peptic ulcer (stomach or duodenal)..... Yes No  
 Trouble swallowing..... Yes No

**GENITOURINARY**

Frequent urination..... Yes No  
 Burning or painful urination..... Yes No  
 Blood in urine..... Yes No  
 Urination at night (> 1/night)?..... Yes No  
 Incontinence or dribbling..... Yes No  
 Decrease in urine stream..... Yes No  
 Kidney stones..... Yes No  
 Sexual difficulty..... Yes No  
 Slow to start/stop urination..... Yes No  
 Female – pain with periods..... Yes No  
 Female – irregular periods..... Yes No  
 Female – contraception type \_\_\_\_\_  
 Female – days in menstrual cycle \_\_\_\_\_  
 Female – date of last menstrual period \_\_\_\_\_

**MUSCULOSKELETAL**

Joint pain..... Yes No  
 Joint stiffness or swelling..... Yes No  
 Back pain..... Yes No

**INTEGUMENTARY (skin, breast)**

Rash or itching..... Yes No  
 Breast pain..... Yes No  
 Breast lump..... Yes No  
 Breast discharge..... Yes No

**NEUROLOGICAL**

Frequent or recurring headaches..... Yes No  
 Light headed or dizzy..... Yes No  
 Convulsions or seizures..... Yes No  
 Numbness or tingling sensations..... Yes No  
 Paralysis..... Yes No  
 Memory loss or confusion..... Yes No

**ENDOCRINE**

Thyroid disease..... Yes No  
 Diabetes..... Yes No  
 Other glandular or hormone problem..... Yes No  
 Explain: \_\_\_\_\_

**OTHER**

Nervousness..... Yes No  
 Depression/Anxiety/Panic..... Yes No  
 Insomnia..... Yes No  
 MRSA Infection..... Yes No

Other concerns not noted above:  
 \_\_\_\_\_

**OFFICE USE ONLY**

I personally reviewed this questionnaire: \_\_\_\_\_ Date: \_\_\_\_\_

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**COSMETIC INTEREST QUESTIONNAIRE**

Cosmetic/Health options of interest to you (Please check all that apply):

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Active FX (fractional CO2 laser)<br><input type="checkbox"/> Facelift<br><input type="checkbox"/> Mini Facelift<br><input type="checkbox"/> Blepharoplasty (eyelid lift)<br><input type="checkbox"/> Rhinoplasty (nasal reshaping)<br><input type="checkbox"/> Forehead Lift / Brow Lift<br><input type="checkbox"/> Cheek Implant<br><input type="checkbox"/> Chin Implant<br><input type="checkbox"/> Lip Augmentation<br><input type="checkbox"/> Otoplasty (ear surgery)<br><input type="checkbox"/> Cosmetic Surgery for Men | <input type="checkbox"/> Botox Cosmetic and/or Dysport<br><input type="checkbox"/> Botox for Hyperhidrosis (excessive sweating)<br><input type="checkbox"/> Dermal fillers including Juvederm & Restylane<br><input type="checkbox"/> Cosmetic Peel<br><input type="checkbox"/> IPL – Photo Rejuvenation<br><input type="checkbox"/> Scar Revision & Resurfacing<br><input type="checkbox"/> Reconstructive Facial Surgery<br><input type="checkbox"/> Dermabrasion<br><input type="checkbox"/> Latisse for eyelash growth<br><input type="checkbox"/> Other: _____<br>_____ |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

- When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	2	3	4	5

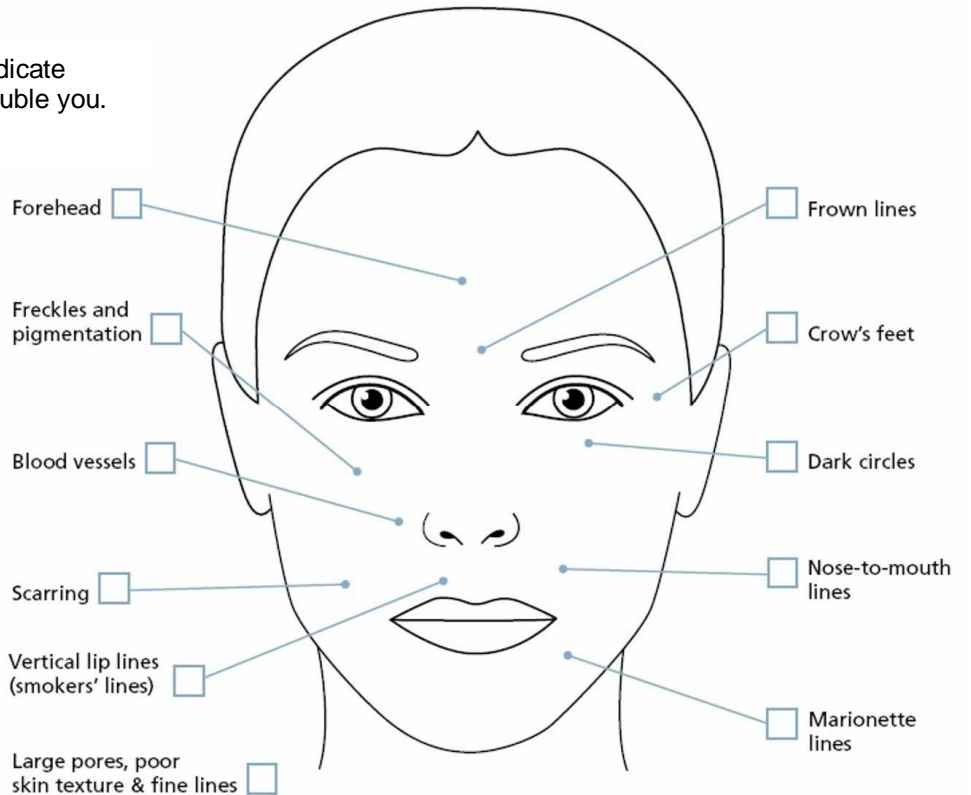
- When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

With respect to signs of aging, please indicate those areas of the face that bother or trouble you.

In the boxes provided, please rate the areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome)

*(Optional)*



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**INFORMED CONSENT FOR MEDICAL PHOTOGRAPHY**

I \_\_\_\_\_ hereby authorize Dr. Stella Desyatnikova, as well as any assistants she may designate, to take photographs of me (including digital images) for diagnostic purposes and to enhance medical records. I agree that these images will remain the property of The Stella Center and that I will request to obtain a copy of these images if needed. I understand that these photos are vital for diagnosis and treatment.

\_\_\_\_\_ **(please initial)**

I consent to my photographs being utilized for lectures, continuing medical education and scientific papers.

I DO

I DO NOT

I consent to my photographs being utilized for patient education, including patient information booklets, as well as "Before and After" displays on our website. I understand that additional consent will be asked of me after the procedure is completed.

I DO

I DO NOT

\_\_\_\_\_  
Signature of Patient or Other Legally Responsible Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Legally Responsible Person to Patient