



The Stella Center
FACIAL PLASTIC SURGERY

Welcome to The Stella Center

Please let us know how you were referred to us:

~ Please check all that apply ~

Internet:

Google.com

Please be more specific, what website did your Google search take you to?

Citysearch.com

Realself.com

www.doctorstella.com

Yelp.com

King 5: Best of Western Washington

Yahoo.com

Bing.com

Friends of The Stella Center:

Dress for Success

Aesthetic Laser Center of Seattle

7 Salon

Medical Dental Building

Pasado's Safe Haven

Other:

Magazine:

Seattle Magazine

Perspective

Other:

Physician, Practitioner or Clinic Name: _____

Other: (please specify below)

Friend's Name: _____

Relative's Name: _____

Other: _____

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

PATIENT REGISTRATION INFORMATION

Date: _____ Social Security # _____ Date of Birth: _____

Name: _____
Last Name First Name Initial

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred: Contact Phone# (_____) _____ E-mail: _____

- Yes No May we leave you a detailed voicemail regarding upcoming or missed appointments on this number?
 Yes No May we use your e-mail address for future communications?
 Yes No Are you interested in receiving discounts & invitations to events via your e-mail address?

Employer: _____ Occupation: _____

In case of emergency, who should we contact? _____

Relationship to you: _____ Contact Phone # (_____) _____

Name of Primary Care Physician/Primary Care Facility: _____

* We will not share your e-mail address, we are committed to your privacy.

BILLING INFORMATION – *Only for Insurance Related Visits* (Please provide your insurance card)

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

Primary Insurance Company: _____ Subscriber ID#: _____ Group # _____

Do you have Medicare? Yes No

Medicare ID#: _____

- Are you seeking care in relation to an accident? Yes No
As a result of work? Yes No
As a result of assault or crime victim? Yes No

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 also understand that appointments cancelled within 24 hours will incur a \$50 cancellation fee.**

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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Age: _____ Height: _____ Weight: _____ Sex: M F

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

Use of Alcohol: Never Rarely Moderate Daily

Use of Caffeine: Coffee Sodas Tea

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 using birth control? Yes No **If so, what type?** _____

HEALTH QUESTIONNAIRE

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
(*Fish oil, ginkgo biloba, Motrin, Aleve, Vitamin E*)

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

- | | |
|--|---|
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Asthma/Allergies _____ | <input type="checkbox"/> Mental Illness _____ |
| <input type="checkbox"/> Bleeding Tendency _____ | <input type="checkbox"/> Reaction to Anesthesia _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Genetic Disorder _____ | <input type="checkbox"/> DVT, Blood Clot _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Pulmonary Embolism _____ |

Patient Signature: _____ **Date:** _____

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

CONSTITUTIONAL SYMPTOMS		Peptic ulcer (stomach or duodenal).....	Yes	No		
Unexplained weight gain or loss.....	Yes	No	Trouble swallowing.....			
Fever or chills.....	Yes	No	Yes	No		
Night sweats/Hot flashes.....	Yes	No	GENITOURINARY			
Fatigue.....	Yes	No	Frequent urination.....	Yes	No	
HEMATOLOGIC/LYMPHATIC		Bleeding or bruising tendency.....	Yes	No		
Anemia.....	Yes	No	Burning or painful urination.....	Yes	No	
EYES		MUSCULOSKELETAL				
Blurred or double vision.....	Yes	No	Joint pain.....	Yes	No	
EARS/NOSE/MOUTH/THROAT		INTEGUMENTARY (skin, breast)				
Hearing loss or ringing.....	Yes	No	Joint stiffness or swelling.....	Yes	No	
Earaches or drainage.....	Yes	No	Back pain.....	Yes	No	
Chronic sinus problem or rhinitis.....	Yes	No	NEUROLOGICAL			
Recurrent nose bleeds.....	Yes	No	Frequent or recurring headaches.....	Yes	No	
Bleeding gums.....	Yes	No	Light headed or dizzy.....	Yes	No	
Sore throat or voice change (hoarseness).....	Yes	No	Convulsions or seizures.....	Yes	No	
Hay fever.....	Yes	No	Numbness or tingling sensations.....	Yes	No	
CARDIOVASCULAR		ENDOCRINE				
Heart trouble.....	Yes	No	Thyroid disease.....	Yes	No	
Chest pain or angina pectoris.....	Yes	No	Diabetes.....	Yes	No	
Palpitation (fast or irregular heart beat).....	Yes	No	Other glandular or hormone problem.....	Yes	No	
Shortness of breath while walking or lying flat	Yes	No	Explain: _____			
Swelling of feet, ankles or hands.....	Yes	No	OTHER			
High blood pressure.....	Yes	No	Nervousness.....	Yes	No	
DVT, blood clot or pulmonary embolism.....	Yes	No	Depression/Anxiety/Panic.....	Yes	No	
Have you ever been on IV antibiotics?.....	Yes	No	Insomnia.....	Yes	No	
RESPIRATORY		MRSA Infection.....			Yes	No
Chronic or frequent coughs.....	Yes	No	Other concerns not noted above:			
Spitting up blood.....	Yes	No	_____			
Shortness of breath.....	Yes	No				
Asthma or wheezing.....	Yes	No				
GASTROINTESTINAL						
Loss of appetite.....	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				

OFFICE USE ONLY

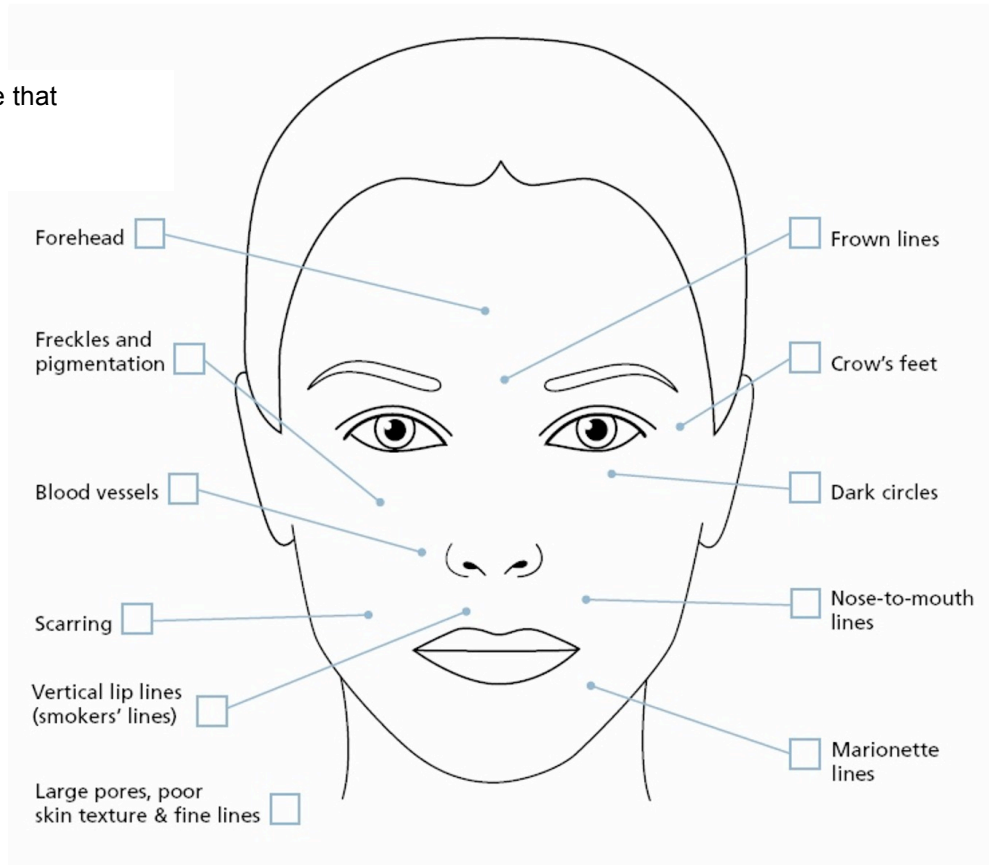
I personally reviewed this questionnaire: _____	Date: _____
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COSMETIC INTEREST QUESTIONNAIRE

Please indicate the cosmetic and health related options that are of interest to you (Please check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Active FX (fractional CO2 laser) | <input type="checkbox"/> Dermal Fillers including Juvederm & Restylane |
| <input type="checkbox"/> Facelift | <input type="checkbox"/> Cosmetic Peel |
| <input type="checkbox"/> Mini Facelift | <input type="checkbox"/> IPL – Photo Rejuvenation |
| <input type="checkbox"/> Blepharoplasty (eyelid lift) | <input type="checkbox"/> Scar Revision & Resurfacing |
| <input type="checkbox"/> Rhinoplasty (nasal reshaping) | <input type="checkbox"/> Skin Tightening |
| <input type="checkbox"/> Forehead Lift / Brow Lift | <input type="checkbox"/> Reconstructive Facial Surgery |
| <input type="checkbox"/> Cheek Implants | <input type="checkbox"/> Dermabrasion |
| <input type="checkbox"/> Chin Implant | <input type="checkbox"/> Latisse for Eyelash Growth |
| <input type="checkbox"/> Lip Augmentation or Plumping | <input type="checkbox"/> Fine Line and Wrinkle Improvement |
| <input type="checkbox"/> Otoplasty (ear surgery) | <input type="checkbox"/> Neck Liposuction |
| <input type="checkbox"/> Botox Cosmetic and/or Dysport | <input type="checkbox"/> Chin Liposuction |
| <input type="checkbox"/> Botox for Hyperhidrosis (excessive sweating) | <input type="checkbox"/> Other: _____ |

Please indicate those areas of the face that concern or trouble you.



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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, and may be utilized for lectures, continuing medical education and scientific papers.

_____ (please initial)

I consent to my photographs being utilized for patient education, including patient information booklets, as well as “Before and After” displays in our office.

I DO

I DO NOT

I consent to my photographs being utilized for “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