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, gingko 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)*

☐ 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:** _____

HEALTH QUESTIONNAIRE (Continued)

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

CONSTITUTIONAL SYPTOMS

- 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
- 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

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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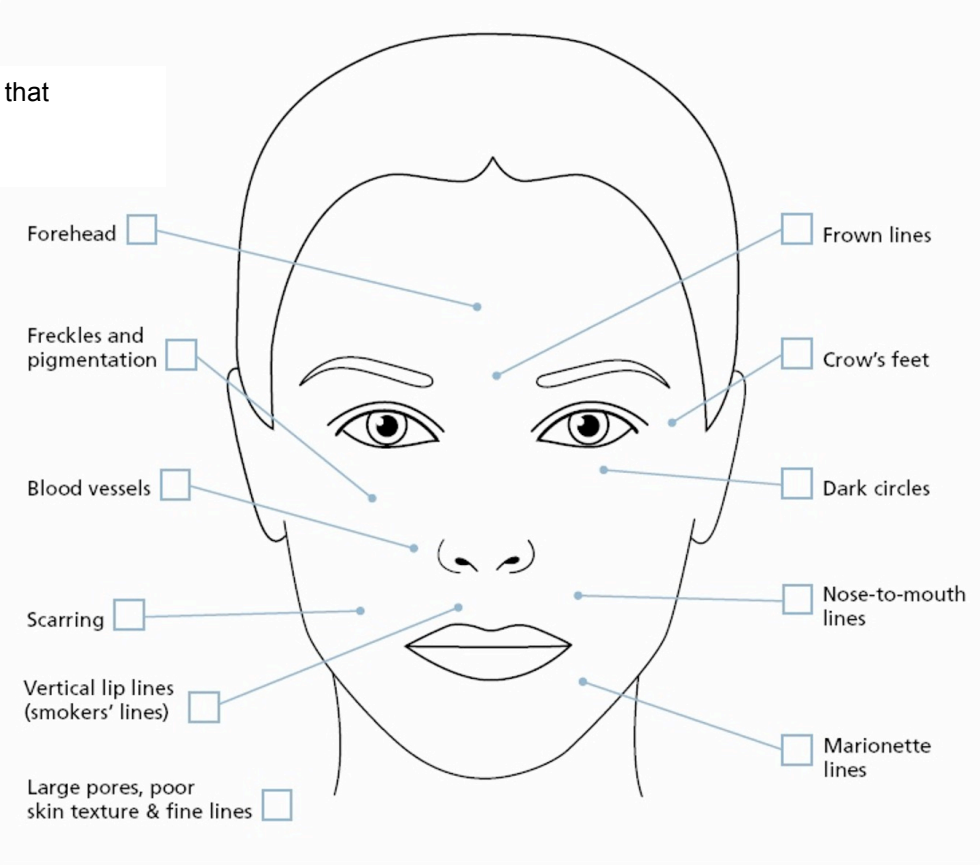
COSMETIC INTEREST QUESTIONNAIRE

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

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

❑ 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