DEMOGRAPHICS AND MEDICAL INFORMATION

Name: _____ DOB: _____ Sex: F/M/T

Height: _____ Weight: _____ E-mail: _____

Cell # :_____ Home #: _____

Address : _____ City :_____ State: _____

Zip: _____ How did you hear about us? _____

Primary Care Physician : _____ Pharmacy :_____

Pharmacy Address: _____ Phone # :_____

IN CASE OF EMERGENCY: _____ Phone # _____

Are you currently pregnant? YES NO Breastfeeding? YES NO

Smoke/Vape? Never Smoked Current heavy smoker Social Smoker Former smoker, year quit_____

Alcohol Use- Weekly? 1-2 Drinks 3-4 Drinks 5+ Drinks Never

PREVIOUS SURGERIES

Any complications from surgeries? Yes No If yes, please explain_____

Any problems with anesthesia? Yes No If yes, please explain

History of Infectious Diseases? Yes No If yes, please explain

History of Autoimmune Disease? Yes No If yes, please explain

History of Herpes Simplex/Cold Sores? Yes No

Have you ever had a DVT? Yes No If yes, please explain

Do you take any Immune-Suppressant Medication? Yes No If yes, what medication?_____

Do you see Cardiology? Yes No If yes, list name _____

Do you take any blood thinners(Aspirin, Aleve, Motrin, Advil, Coumadin, Plavix, Fish Oil, Vitamin E)
Yes No

Do you have any facial implants? (Chin, Cheek, Mouth) Yes No If yes, please explain_____

Have you had any previous aesthetic treatments? Yes No If yes, please explain_____

ALLERGIES

No Known Allergies Latex Allergy Other- Please List Below

Medication or Allergy	Adverse Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Prescriptions- including over the counter, supplements, and herbal/natural medications- Please list and include dosage and frequency

1.) _____
2.)_____
3.)_____
4.)_____
5.)_____

Please circle if you or any family member (specify) have been affected be the following conditions:

Arthritis	Diabetes	High Blood Pressure	Skin Cancer
Asthma	Excessive Bruising	HIV/AIDS	Stroke
Blood Clots	Headaches	Hypertension	Thyroid Issues
Breast Cancer	Heart Disease	Melanoma	Tuberculosis
COVID-19	Heartburn	Pulmonary Disorders	Cancer- Other Type
Depression	Hepatitis A-B-C	Seizures	Other_____

_____ _____
Patient Signature Date

THE
WILLIAMS
CENTER

Notice of Privacy Practices

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment/services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

The terms of this notice apply to all records containing you IIHI that are created or retained by our practice. We reserve the right to revise or amend the Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current notice in our office in a visible location at all times. You may request a copy of our most current notice at any time.

If you have any questions about this notice, please contact:
Susan Sullivan
Director of Operations
1072 Troy-Schenectady Road
Latham, NY 12210

I, _____, have received a copy of The Williams Center Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____
Date of Birth

Please List people who we are able to share your information with (including spouses, partners, family or friends)

_____ Relationship: _____

_____ Relationship: _____

Financial Policy-Cosmetic

Cosmetic Services: Many procedures performed by The Williams Center and its affiliates may be deemed to be cosmetic in nature. The Williams Center and its affiliates will not submit a claim or provide medical records to any insurance company for reimbursement on behalf of the patient for a cosmetic procedure. Payment for services rendered will be due at the time of visit (or 3 weeks prior to a surgical procedure).

In-Office Procedures: I understand that if I cancel with less than two weeks' notice or if I no-show for my appointment, I will be charged a $250 non-refundable cancellation fee. I also understand that if I reschedule my appointment more than two times, I may not be able to back on the schedule, it is up to the mangers/providers discretion.

I, _____ have read the policy above regarding my financial responsibility to The Williams Center for services provided. I agree to pay The Williams Center at the time of my appointment (or 3 weeks prior to a surgical procedure).

_____ _____

Patient Signature Date

THE
WILLIAMS
CENTER

Contact Consent Form

By providing your email address and phone number, you authorize The Williams Center and its affiliates to you send you information regarding appointment reminders, medical/scheduling information, paperwork, upcoming events, specials, monthly newsletter, etc. via email and text messages

_____

Patient Signature

_____

Date

THE WILLIAMS CENTER

Computerized Imaging Consent

In an attempt to determine if my expectations are realistic during my initial consultation with the Provider, I will be imaged on the United/Vectra 3D Digital System Computer Imager and/or FotoFinder. The system software is utilized to view and/or alter the features the Provider will address with regard to the type of surgical or non-surgical procedure I may be interested in or is recommended during my consultation.

It is emphasized that the image the Provider will create using the United/Vectra 3D Digital System Computer Imager and/or FotoFinder is an ideal goal that the Provider believes is achievable with the surgical or non-surgical procedure that will be proposed during my consultation. However, because of the unpredictability of healing and biology, the desired goal is in no way promised as an outcome of surgery or procedure.

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing, and/or certifying purposes by The American Board of Plastic Surgery, Inc.

These photos/images are for your medical chart only, unless otherwise specified and agreed upon in a separate signed document.

Patient _____ Date _____

Witness _____ Date _____