THOMAS D. TOOHEY, M.D.

PATIENT INFORMATION

LAST NAME _____ FIRST NAME_____ M.I._____

BIRTH DATE _____ SOCIAL SECURITY NUMBER #_____

MARITAL STATUS Single□ Married□ Divorced□ Widowed□

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE_____

EMAIL ADDRESS _____

HOME #_____ MOBILE #_____

OCCUPATION _____ WORK #_____

EMPLOYER NAME _____

How were you referred to Dr. Toohey's office? _____

SPOUSE OR EMERGENCY CONTACT

LAST NAME _____ FIRST NAME_____ M.I._____

BIRTH DATE _____ SOCIAL SECURITY NUMBER#_____

RELATION TO PATIENT: Spouse□ Parent□ Self □ Other□_____

MARITAL STATUS Single□ Married□ Divorced□ Widowed□

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE_____

EMAIL ADDRESS _____

HOME PHONE#_____ MOBILE #_____

WORK #_____

CONSENT FOR TREATMENT/ASSIGNMENT OF BENEFITS/RELEASE OF MEDICAL INFORMATION*:* I GIVE MY CONSENT TO THOMAS D. TOOHEY, M.D. TO PROVIDE MEDICAL CONSULTATION AND/OR TREATMENT. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR All CHARGES INCURRED BY ME AND/OR MY DEPENDENTS. BY SIGNING THIS FORM, I AM ACKNOWLEDGING THAT I HAVE BEEN ADVISED THAT THE OFFICE OF **THOMAS D. TOOHEY, M.D. IS NOT CONTRACTED WITH ANY INSURANCE CARRIER**. I AUTHORIZE THOMAS D. TOOHEY, M.D. AND STAFF TO RELEASE TO MY INSURANCE CARRIER ANY INFORMATION CONCERING HEALTHCARE, TREATMENT OR SUPPLIES TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES.

Patient Signature: _____ Date_____

Medical Information

Patient Name_____ Today's date_____

PLEASE PRINT CLEARLY AND COMPLETE ALL QUESTIONS AND INDICATE "NONE" IF NONE APPLIES.

Do you have any serious illnesses or health problems such as asthma, high blood pressure, heart trouble, heart attack, diabetes, thyroid problems, hepatitis stroke or glaucoma? Please explain any yes answers:

_____

_____

Do you smoke? Yes / No If yes how often? _____

Do you drink alcoholic beverages? Yes / No If yes how often? _____

Do you bleed easily from cuts, surgery, tooth extraction etc.? Yes/No If yes please explain:

_____

Female only:

Number of pregnancies _____ ***Number of children*** _____ ***Year of last pregnancy*** _____

Please list ALL previous surgery including, C-sections, oral surgery, or previous plastic surgery:

Operation	Doctors Name	Year

_____

_____

_____

_____

_____

Have you had any complications or problems with surgery or anesthesia, including local anesthesia? If yes, please explain.

_____

_____

Have you ever required unusually large amounts of local anesthesia for medical or dental procedures? Yes / No
Has anyone in your immediate family ever had problems with anesthesia? Yes / No

ALLERGIES OR SENSITIVITES TO MEDICATIONS: Please list, if none please state:

_____

_____

MEDICATIONS: Please list all medications you are presently taking:

_____

_____

Thomas D. Toohey, M.D.

Diplomate of the American Board of Plastic Surgery

Photo/Video Consent Form

In connection with the medical services which I am receiving from my physician, Thomas Toohey, M.D. I consent that photographs and/or video may be taken of me or parts of my body under the following conditions:

- These photographs/video may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him or her.

- The photographs/video shall be taken by my physician or a photographer approved by my physician.

- The photographs/video shall be used for medical records and if in the judgment of my physician, medical research, education, or science will be benefited by their use, such photographs/video and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, in print or electronic format including Dr. Toohey's website, or used for any other purpose which he/she may deem proper in the interest of medical and patient education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.

- The photographs/video and information relating to my case may be published and republished either separately or in connection with each other in electronic format including social media sites (ie. Instagram, Facebook, Snapchat etc.) and others which Dr. Toohey and staff may deem proper.

- The aforementioned photographs/video may be modified in any way that my physician, in his/her discretion, may consider desirable.

- I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will not effect on any actions taken prior to my revocation.

- I understand I may refused to sign this authorization and such refusal will have no effect on the treatment I receive from Dr. Toohey.

- I hereby grant permission for the use of any of my medical records including illustrations, photographs/video 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.

- I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because the American Society of Plastic Surgeons ("ASPS") will not be receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be re-disclosed by ASPS.

_____ _____

Printed Name Signature Date

_____

Physician Signature Date

HIPAA Compliance Patient Consent Form for Email and Virtual Consultations

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and is disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Information stored on our computers is encrypted
- Most popular email services (ie. Hotmail, Gmail, Yahoo) do not utilize encrypted email
- When we send you an email or you send us an email, the information that is sent may not be encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
- HIPAA guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.
- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

This consent was signed by: _____

Print Name

Signature: _____ Date: _____

Witness: _____ Date: _____