Joseph L. Kiener, M.D., F.A.C.S.

Patient Registration Form

Patient Information

First Name	MI	Last Name		Sex ☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)	Age	SSN	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other	
Patient Address		Apt #	City, State	Zip
Home Phone ( ) -		Cell Phone ( ) -		
Email Address		Employer		☐ Full Time ☐ Part Time
Preferred Pharmacy Name		Preferred Pharmacy Address		Preferred Pharmacy Phone ( ) -

Physician and Referral Information

Primary Care Physician	City, State	Phone ( ) -
Referring Physician	City, State	Phone ( ) -
How did you hear about us?		

Insurance Information – *Not Required for Cosmetic Patients*

Primary Insurance	Policy Number	Group Number	
Subscriber's Full Name	*DOB (MM/DD/YYYY)*	*SSN*	*Sex* ☐ *Male* ☐ *Female*
Employer	☐ *Full Time* ☐ *Part Time*	*Phone* ( ) -	*Relationship to Patient*
Secondary Insurance	Policy Number	Group Number	
Subscriber's Full Name	*DOB (MM/DD/YYYY)*	*SSN*	*Sex* ☐ *Male* ☐ *Female*
Employer	☐ *Full Time* ☐ *Part Time*	*Phone* ( ) -	*Relationship to Patient*

Financially Responsible Party

Relationship to Patient: ☐ Self (If self, please skip to Emergency Contact) ☐ Spouse ☐ Parent ☐ Other

First Name	MI	Last Name		Sex ☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)	Age	SSN	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other	
Address		Apt #	City, State	Zip
Home Phone ( ) -		Cell Phone ( ) -		
Email Address		Employer		☐ Full Time ☐ Part Time

Emergency Contact Information

First Name	MI	Last Name		Relationship to Patient
Address		Apt #	City, State	Zip
Home Phone ( ) -		Cell Phone ( ) -		

Assignment and Release of Records

I hereby authorize payment directly to Joseph L. Kiener, M.D., F.A.C.S. for any monetary benefits from my medical surgical plans. I understand that I am responsible for my account regardless of insurance involvement. I hereby authorize Joseph L. Kiener, M.D., F.A.C.S. to release my medical records to my insurance companies. I give permission for the use of my photographs or x-rays in medical lectures or publications for scientific purpose. I have received the notice of privacy practices and I have been provided the opportunity to review it.

Patient or Guarantor's Signature

Date (MM/DD/YYYY)

Joseph L. Kiener, M.D., F.A.C.S.

Patient Medical History Form

Patient's Full Name | Age | Height | Weight

Today's Date | Reason for Today's Visit

Have you seen another physician for the same reason you are here today? ☐ Yes ☐ No

Have you received any narcotic drug within the last 30 days? ☐ Yes ☐ No
If yes, please list the name of the prescribing physician:

Current Medications (Please include vitamins and herbal supplements, insulin, steroids, inhalers, oxygen, eye-drops, etc.)

Drug	Dose	Frequency	Drug	Dose	Frequency

Allergies and Adverse Reactions

Do you have any drug allergies? (Include allergies to antibiotics, latex, dye, skin preps, and pain medications if applicable)
☐ Yes ☐ No

If yes, please list:

Substance Use

Alcohol
☐ Yes (Minimal/Moderate/Heavy/Previously heavy) ☐ No

Do you use recreational drugs? (Marijuana, cocaine, heroin, etc.)
☐ Yes ☐ No

Tobacco
☐ Yes (_____ packs per day for _____ years) ☐ Smokeless tobacco or vaping ☐ Previously smoked (Stopped in year ________) ☐ No

Past Medical and Surgical History

Please check any of the following conditions you currently have or have had in the past

☐ AIDS or HIV Infection
☐ Anemia
☐ Angina
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Cardiac Pacemaker
☐ Chest Pain
☐ Cold Sores
☐ Concussion
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Epilepsy/Convulsions
☐ Fainting
☐ Fever Blisters
☐ Glaucoma
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis/Jaundice
☐ High Blood Pressure
☐ Joint Replacement or Joint Implant
☐ Kidney Disease
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Mental Illness
☐ Mitral Valve Prolapse
☐ Psychological Problems
☐ Radiation Therapy
☐ Respiratory or Breathing Problems
☐ Rhematic Fever
☐ Seizure
☐ Stroke
☐ Substance Abuse
☐ Suicide Attempts
☐ Thyroid Problems

Have you had other cosmetic surgeries in the past? ☐ Yes ☐ No
If yes, please list procedures and dates:

Please list all operations, major injuries, and hospitalizations for which you have been treated:

Please check any of the following conditions that have occurred in your family

☐ Anesthesia Reaction
☐ Asthma
☐ High Blood Pressure
☐ Cancer
☐ Lung Disease
☐ Diabetes
☐ Melanoma
☐ Eczema
☐ Skin Cancer
☐ Heart Disease

The following questions help assess your risk for developing a blood clot or deep vein thrombosis (DVT) with surgery:

Have you had a previous DVT? ☐ Yes ☐ No
Has anyone in your family ever had a DVT? ☐ Yes ☐ No
Will you need to travel more than 30 minutes to our office for your appointments? ☐ Yes ☐ No

For women only:

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
Have you ever had a miscarriage? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Are you taking oral contraceptives? ☐ Yes ☐ No
Do you perform self-breast exams? ☐ Yes ☐ No

I have fully completed, reviewed, and verified that all of the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient or Guarantor's Signature

Date (MM/DD/YYYY)

Joseph L. Kiener, M.D., F.A.C.S.
Diplomate, American Board of Plastic Surgery

Patient Name : ______________________________

Authorization to Release Medical Information

We understand there are times when you may want a family member or friend to act as your representative for things such as picking up prescriptions, making or canceling appointments and speaking with our staff or physician. Please help us protect your privacy by providing their names below.

**If you do not want to put anyone on this form-please put "None" on line 1

Joseph L. Kiener, MD Chartered may release medical information to:

1)________________________________Relation ______________________________

2)________________________________Relation ______________________________

3)________________________________Relation ______________________________

4)________________________________Relation ______________________________

Disclosure:

If you consult with Dr. Kiener for a procedure that could be considered as an Elective or Cosmetic procedure and ask us to contact your Insurance Company for an approval, please be aware that your consultation will be billed to your Insurance Company and you will be responsible for all applicable co-pays or out of pocket expenses.

________________________________ ______________________

Signature of Patient or Legal Representative Date

Member
American Society
for Aesthetic Plastic
Surgery, Inc.

530 Hammill Lane
Reno, Nevada 89511
Phone # 775-825-1234
Fax # 775-825-2633

Member
American Society
of Plastic
Surgeons, Inc.

Joseph L. Kiener, M.D., F.A.C.S.
Sierra Institute for Plastic Surgery
Diplomate, American Board of Plastic Surgery

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I consent to the taking of photographs or videotapes of me or parts of my body, by Dr. Kiener or his designee, in connection with the following plastic surgery procedure(s)

____

to be performed by Dr. Kiener. I further consent to the release by Dr. Kiener to the American Society for Aesthetic Plastic Surgery, Inc. ("ASAPS") of such photographs, videotapes or case histories.

I understand that such photographs, videotapes or case histories may be published by Dr. Kiener and/or ASAPS and/or any party acting under their license and authority in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any action taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Kiener.

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 ASAPS is not 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 redisclosed by ASAPS.

I release and discharge Dr. Kiener, ASAPS, and all parties acting under their license and authority from all rights that I may have in the photographs, videotapes or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

_______________________________ _______________________

Patient Date

WITNESS/PHYSICIAN:___________________________________

I have read the above Authorization and Release. I am the parent, guardian or conservator of _______________________________, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

_______________________________ _______________________

Patient/Guardian Date

Member
American Society
for Aesthetic Plastic
Surgery, Inc.

530 Hammill Lane
Reno, Nevada 89511
Phone # 775-825-1234
Fax # 775-825-2633

Member
American Society
of Plastic
Surgeons, Inc.