facial plastic surgery
Frank P. Fechner, MD

Date

Dear

Welcome to our practice.

In order to best prepare for your consultation with Dr. Fechner, we ask that you please fill out the enclosed documents and bring them with you to your appointment, completed. It will save you and the doctor valuable time.

Dr. Fechner's consultation fee is $200. If you need to cancel your appointment, we kindly ask that you give us at least 48 hours notice. *Your credit card will be charged the $200 consultation fee* if you do not call us 2 days before or you do not show for your scheduled appointment.

Thank you and we look forward to meeting you.

Sincerely,

Penny McLaren

Office Manager

428 Shrewsbury Street, Worcester MA 01604, Tel: (508) 754 4000, Fax: (508) 754 4222, www.DrFechner.com

Office Use Only --

Updated ___/___/___ Updated ___/___/___
Updated ___/___/___ Updated ___/___/___
Updated ___/___/___ Updated ___/___/___

Frank P. Fechner, M.D.

Patient Registration Form

Date: ___________________

Patient ID #:____________

Name / Address

Last Name: ____________________________ First Name: ______________________ MI: _______
Address 1: ____
Address 2: ____
City: ____ State: _____ Zip _________

Information

SSN: _____-____-_______ **Date of Birth: ______________**
Home Phone (___)____-_____ Sex: Male / Female

Marital Status (circle one)
Married, Single,
Divorced, Widow, Oth.

Spouse / Next of Kin: _______________________________
Employer: ____ Occupation: ______________

Primary Care MD: __________________________ Referring MD: __________________________
PCP Address: ____
PCP Tel Nr: ____________________________

Insurance Information

Primary Insurance Company	Identification or Certificate #	Group Number
Name of insured (if not self): ______________________		Relation to Insured Self, Spouse, Child
Second Insurance Company	**Identification or Certificate #**	**Group Number**
Name of insured (if not self): ______________________ Insured Address: ________________________________		Relation to Insured Self, Spouse, Child

Other Insurance

Is this Workers Comp.? Y / N Is this Motor Vehicle? Y / N Is this Personal Injury? Y / N

Authorization and Financial Policy:

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR MEDICAL BENEFITS.

I AUTHORIZE PAYMENT OF ALL MEDICAL BENEFITS TO FRANK P. FECHNER, M.D. FOR SERVICES PROVIDED.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL BALANCES NOT PAID BY MY INSURANCE COMPANY.

Your Signature: ______________________________

Photographs

During your treatment course photographs may be taken. Those photographs will become part of the medical record. Under the Health Insurance Portability and Accounting Act of 1996 (HIPAA), those photographs may be supplied as part of your medical records to medical specialty boards and medical staffs reviewing the treating physician's credentials under a "Business Associate Contract" prescribed by HIPAA.

Your Signature: ______________________________

Frank P. Fechner, MD – Facial Plastic Surgery

Patient Health & Skin History Form

Name ____ Today's Date ____________________

Age _______ Sex _______ Height ________ Weight _________

How did you hear about Dr. Fechner? ____

Procedures I would like to discuss with the doctor:

Facial Rejuvenation: Necklift Facelift Eyelid Correction Brow Lift Fat Transfer

Nose: Cosmetic Corrective Breathing Problems

Profile: Chin Enhancement Cheek Enhancement Face/Neck Liposuction

Ears: Reduce Prominence Reduce Earlobe Size Repair Torn Earlobe

Skin: Skin Growths/Moles Wrinkles Pigmentation/Age Spots Redness/Rosacea Roughness
Broken Blood Vessels Scars Acne Scarring Acne Other _________________________

Injectables: Botox Restylane/Juvederm Radiesse Sculptra Artefill Lip Enhancement

Other Procedures: Hair Removal Micro Peel Facial Peel Dermabrasion Photofacials

Other: ____

____

Please indicate in your own words what concerns you: ____

____

Have you ever had or used:

yes no

" "" ""Retin A
" "" ""Chemical Peel
" "" ""Microdermabrasion
" "" ""Laser, type _________________
" "" ""Botox."F {ur qtv
" "" ""Dermal Fillers (Restylane, Collagen, etc.)
" "" ""Kplgevcdng"Silicone
" "" ""Accutane
" "" ""Herpes (or cold sore) medication
" "" ""Oral contraceptives

How long have you thought about surgery? _____________

Do you feel ready now? ____________________________

How would your life change from an improved appearance?

____

Have you consulted other doctors about this surgery?

"yes "no When: _____________

Have you had cosmetic surgery in the past? "yes " "no

Please list procedure(s) and year _______________________

____

____

Doctor'Name: _______________ Good experience? _____

Satisfactory result? ________________________________

Sun exposure:
Past: Little Excessive
Present: Little Excessive

Tanning Beds:
Past: Little Excessive
Present: Little Excessive

Sunscreen:
Never Occasional Daily

Review of Systems

Please circle any symptoms below that you feel are affecting your health:

General: Fatigue, unexplained weight gain/loss, fever, chills, night sweats, sleep problems, pain.

Skin: New or changing skin growth, unexplained rash.

Head: Headaches, recent trauma.

Eyes: Blurred/loss of vision, eye pain, discharge, glasses/contacts, **dryness, lasik, glaucoma**

Ears: Excessive noise exposure (loud music), ear pain, loss of hearing, ringing in ears, drainage.

Nose: Frequent bloody nose, sinus pain, post nasal drainage, congestion.

Mouth: Tooth pain, oral sores, bleeding.

Throat: Hoarse voice, voice changes, pain or difficulty swallowing, frequent soreness or swelling.

Neck: Pain, stiffness, swelling.

Chest: Breast changes or lumps, nipple discharge, chest wall pain.

Lungs: Cough, shortness of breath, wheezing.

Heart: Murmurs, palpitations, pain with exertion, passing out.

Stomach: Frequent nausea, vomiting, diarrhea, constipation, abdominal pain, bleeding, constipation.

Urinary Tract: Frequent urination, pain on urination, blood in urine.

Musculoskeletal: Joint pain, swelling, muscle pain, stiffness, restricted movement, swelling.

Nervous System: Loss of consciousness, dizziness, seizures, weakness or numbness in any body part, tremors, twitching.

Mental Health: Feelings of nervousness/anxiety/panic, crying spells, depression, confusion, problems concentrating.

Blood/Lymph: Anemia, bleeding tendency, easy bruising, swollen/painful lymph nodes.

Other: ____

Personal/Family Medical History

Please check where you or members of your family, have had the following:

	Yourself	Father	Mother	Brother(s)	Sister(s)
AIDS/HIV					
Alcoholism					
Anemia					
Anxiety					
Arthritis					
Asthma					
Bleeding Problem					
Easy Bruising					
Cancer					
Cirrhosis					
Dementia					
Depression					
Diabetes Mellitus					
Eczema, Hives Rash					
Eye Problem/Glaucoma					
Heart Disease/Murmur					
Hemophilia					
High/Low Blood Pressure					
High Cholesterol					
Kidney/Bladder Problem					
Liver Disease/Jaundice					
Lung Disease					
Mental Illness					
Osteoporosis					
Parkinson's Disease					
Peptic Ulcer Disease					
Phlebitis/Blood Clot					
Rheumatic Fever					
Seizures/Epilepsy					
Sickle Cell Disease					
Stroke					
Thallasemia					
Thyroid Disease					
Tuberculosis					

Other: ____

____

____

Allergies:
- □ I have NO Allergies
- □ Allergic to Medications: ____________________
  Symptom: ____________________
- □ Latex; Symptom: ____________________
- □ Other ____________________

General/Social Information:

Would you be able to lie on your back comfortably for 3 hours? □ No □ Yes

Do you smoke? □ No □ Yes

□Cigarettes □Cigars □Pipe □Other ____________

If yes, how much? __________ How long? __________

Are you a former smoker? □ No □ Yes

If yes, when did you quit? ________________

Do you drink alcohol? □ No □ Yes

If yes, how much and how often do you drink? _____

__________ per ____________________

# of drinks (day, week, month or year)

Have you ever used intravenous or recreational drugs?

□ No □ Yes. If yes, please list: ________________

Are you pregnant or nursing? □ No □ Yes

With whom do you live?

□ I live alone. □ I live with ________________

Current occupation/employment:

□ Retired □ Disabled □ Working as ______________

Who do you want notified in case of emergency?

(Name)	(relationship)	(phone #)

Please list all current medications

Prescription Drugs:

Name	Dose	Reason for taking it

Over the counter: (aspirin, Tylenol, antihistamines, herbals, vitamins, etc)

Name	Dose	Reason for taking it

Please list current illnesses/health problems:

____
____
____
____

Please list surgeries and hospitalizations:

	Year

I understand that the above information is important for my safety. I therefore certify that all of the above answers are true and correct to the best of my knowledge. I also give Dr. Fechner permission to contact my physician for any information concerning my medical history.

All professional Services are charged to the patient. The patient is responsible for all fees regardless of insurance coverage. I understand that I am responsible for all fees regardless of insurance coverage. I understand that I am responsible for my bill. I hereby assign all medical and surgical benefits, to include major medical benefits such as Medicare, private insurance, and other plans to Frank P. Fechner, MD. I give authorization to release any information to my insurance company that it may need. I, the undersigned patient, do hereby give my consent for Frank P. Fechner, MD to furnish treatment considered necessary and proper in diagnosing and/or treating my physical and cosmetic condition(s).

____
Patient Signature

□ Form completed by ____________________
Person other than patient

____
Physician Signature

____
Date Reviewed by Dr. Fechner

facial plastic surgery
Frank P. Fechner, MD

EYE EVALUATION SHEET

Your Name .... Date of Birth ....

Your "Eye Doctor's" Name & Address ....

.... Date of last eye examination or office visit ....

1. At your last examination were you told you have **any** problems with your eyes? .... **Yes No**

   If yes, please explain ....

2. Do you require glasses or contact lenses? (Circle which) .... **Yes No**
3. Have you had any injuries or surgery to the eyes or lids? .... **Yes No**

   By whom? Please explain ....

4. Do you feel your eyes or lids swell excessively? .... **Yes No**
5. Are you bothered by frequent irritations or "allergies" of the eyes or lids? (Circle which) **Yes No**
6. Do you now take or have you ever taken medications or drops for the eyes? .... **Yes No**

   If yes, please explain ....

7. Are you bothered by "dry eyes"? .... **Yes No**
8. Do your eyes "water" or tear spontaneously and without emotional stimulation? .... **Yes No**
9. Do you now have or have you ever had any visual problems with one or both eyes? **Yes No**

   If yes, please explain ....

10. Are there any other problems we have not asked about that you feel we should know? **Yes No**

    If yes, please explain ....

Please Read the Following and Carry Out the Instructions

---

1. Cover your **RIGHT** eye and read THIS sentence with your **LEFT** eye.

   Are you able to read it comfortably? .... **Yes No**

   ..... with glasses ..... without glasses

2. Cover your **LEFT** eye and read THIS sentence with your **RIGHT** eye.

   Are you able to read it comfortably? .... **Yes No**

   ..... with glasses ..... without glasses

3. Is there any difference in your vision? .... **Yes No**

   Please indicate: ..... Right stronger

   ..... Left stronger

I signify that to the best of my knowledge the information provided above is accurate.

Signed (Patient): .... Date ....

428 Shrewsbury Street, Worcester MA 01604, www.DrFechner.com

Directions to Dr. Fechner's Office

428 Shrewsbury St.
Worcester, MA 01604
Tel. (508) 754-4000

PARKING LOT: Behind Main Building on McRae Court

From East or West:
Take Mass Pike (I-90) to Exit 10. Follow I-290 East to Exit 15. Stay straight on Shrewsbury St. for 1.1 miles. At Piccadilly Plaza, make a U-turn. Office will be on right. (Look for sign and green awnings on house). Take right onto McRae Ct. for parking and entrance at rear of building.

From I-495:
Take I-290 West to Exit 16, Central St. Downtown Worcester. At end of exit, turn left. At second light, take left onto Shrewsbury St. Follow this road for 0.9 miles. Make a U-turn at Piccadilly Plaza. Office will be on right. (Look for sign and green awnings on house). Take right onto McRae Ct. for parking and entrance at rear of building.

From I-190:
Take I-290 West to Exit 16, Central St. Downtown Worcester. At end of exit, turn left. At second light, take left onto Shrewsbury St. Follow this road for 0.9 miles. Make a U-turn at Piccadilly Plaza. Office will be on right. (Look for sign and green awnings on house). Take right onto McRae Ct. for parking and entrance at rear of building.

From I-290 (Eastbound):
Take Exit 15 and stay straight on Shrewsbury St. for 1.1 miles. At Piccadilly Plaza, make a U-turn. Office will be on right. (Look for sign and green awnings on house). Take right onto McRae Ct. for parking and entrance at rear of building.

From I-290 (Westbound):
Take Exit 16, Central St. Downtown Worcester. At end of exit, turn left. At second light, take left onto Shrewsbury St. Follow this road for 0.9 miles. Make a U-turn at Piccadilly Plaza. Office will be on right. (Look for sign and green awnings on house). Take right onto McRae Ct. for parking and entrance at rear of building.

From Rt. 9 (Eastbound):
Cross I-290. Follow Belmont St. straight to Piccadilly Plaza. Take right at U-Haul onto Shrewsbury St. Office is on right. (Look for sign and green awnings on house). Take right onto McRae Ct. for parking and entrance at rear of building.

From Rt. 9 (Westbound):
Cross bridge over Lake Quinsigamond. Follow this road straight 0.6 miles. Pass UMASS Medical Center on right. Then stay in left lane and at U-Haul bear left onto Shrewsbury St. Office is on right. (Look for sign and green awnings on house). Take right onto McRae Ct. for parking and entrance at rear of building.