Dr. Samieh Sam Rizk, M.D., F.A.C.S
Manhattan Facial Plastic Surgery, P.L.L.C.
Director
1040 Park Avenue
New York, N.Y. 10028

Name: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Age: _____ Sex: M: ____ F: ____ Student? FT: ___ PT: ___

Cell Phone #: _____ Work Phone #: _____

Email Address: _____

(With my signature on file, I give Dr. Rizk and Staff permission to email me regarding my Procedures and finances) **Signature**: _____

Marital Status: Married: ____ Single: ____ Widowed: ____ Divorced: ____

Allergies To Medicine: _____

Primary Care Doctor (first and last name): _____ Address: _____

Name of Dermatologist: _____ Phone#: _____

Parent / Guardian / Spouse Information

Name: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____

Health Questionnaire

Name: _____ Date: _____

Reason for today's visit: _____

1. Have you suffered from?

	Yes	No
Heart Disease	_____	_____
High Blood Pressure	_____	_____
Heart Attack	_____	_____
Emphysema	_____	_____
Asthma	_____	_____
Blood Disease	_____	_____
Kidney Disease	_____	_____
Glaucoma	_____	_____
Diabetes	_____	_____
Jaundice/Hepatitis	_____	_____
Cancer	_____	_____
Anemia	_____	_____
Easy Bruising	_____	_____
Facial Trauma	_____	_____
Dry Eyes	_____	_____
Eating Disorder	_____	_____
Depression	_____	_____
Psychological Disorder	____	_____

Elaborate as needed: _____

_____

_____

2. Do you take?

St. John's Wort	_____	_____
Aspirin	_____	_____
Ginko	_____	_____
Vitamin E	_____	_____

3. Have you have ever taken?

Fen Fen	_____	_____
Accutaine	_____	_____

4. What medications do you use?

_____

_____

_____

5. What medication are you allergic to?

_____

_____

6. Do you have any other medical problems?

7. Have you ever been hospitalized?
yes ___ no ___ please describe:

_____

_____

_____

8. Have you ever had cosmetic surgery?
Yes ___ no ___ please describe:

_____

_____

_____

9. Have you ever had any other surgery?
Yes ___ no ___ please describe:

_____

_____

_____

10. Have you ever had any of the following habits? Yes ___ no ___
smoking

Frequency _____
Alcohol
Frequency _____
Recreational Drugs
Frequency _____

11. Do you have any caps, crowns, bridges, or loose teeth?

_____

_____

12. Are you currently undergoing dental work? _____

_____

13. How did you hear of our office?

___Google ____ TikTok
___ Yahoo ___ Facebook
___ AOL ___ Instagram
_____Other Website
___ Friend/Family ___ Physician
Name of Physician, Friend Or Family who referred you_____

Manhattan Facial Plastic Surgery, PLLC
Park Avenue Facial Surgery, PLLC
1040 Park Avenue
New York, NY 10028
(212) 452-3362

Patient Acknowledgment

We are required by law to maintain the privacy of protected health information and to provide individuals with our Notice of Privacy Practices which explains our legal duties and privacy practice with respect to protected health information. If you have any questions, please contact our Privacy Officer in person or by phone at (212) 452-3362.

Your signature below is only acknowledgment that you have received a copy of our Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

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Manhattan Facial Plastic Surgery, PLLC
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1040 Park Avenue
New York, NY 10028
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Photography Consent

I, _____, authorize Dr. Samieh Rizk, Manhattan Facial Plastic Surgery, PLLC, and/or Park Avenue Facial Surgery, PLLC, their employees, agents and assigns, to photograph and/or video me prior to, during, and after any surgery(ies) or procedure(s) that I have or may receive, and that such photographs, videos, reproductions and duplications shall become the property of Dr. Samieh Rizk, Manhattan Facial Plastic Surgery, PLLC, and/or Park Avenue Facial Surgery, PLLC.

*I understand that the purpose of this authorization is for use in my medical records, and that by signing this consent I am **not** authorizing the use of my photographs or videos (or any reproductions and duplications thereof) for purposes of distribution, viewing at the office, use in scientific journals or posting on websites.*

Signature: _____ Date: _____

I, the undersigned acknowledge that I have received the following disclosures from the practice.

- Facility Information
- Patient Bill of Rights
- Complaint Resolution Policy
- Billing Information
- Facility Ownership Disclosure
- Information on Pain Assessment
- Physician (s) Qualification
- Photo Consent
- Patient Acknowledgement (HIPPA Notice of Privacy Practices)

Name: _____

Signature: _____