

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

What procedure are you interested in?: _____

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: _____

Samieh S. Rizk, M.D., F.A.C.S.
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(212) 452-3362

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: _____