

SPOKANE CENTER FOR FACIAL PLASTIC SURGERY

Date: \_\_\_\_\_
Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_
Referring Physician: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

GENERAL INFORMATION

Male [ ] Female [ ] Marital Status M [ ] S [ ] D [ ] W [ ]

Occupation \_\_\_\_\_ Disabled [ ]

Smoking History:

[ ] I have never smoked [ ] I am exposed to smoke at work
[ ] I currently smoke Years \_\_\_\_\_ Packs per day \_\_\_\_\_
[ ] I previously smoked Quit date \_\_\_\_\_ Years Smoked \_\_\_\_\_

Other: \_\_\_\_\_
Does anyone in the home smoke? Yes [ ] No [ ]

Alcohol use: Yes [ ] No [ ] Drinks per day: \_\_\_\_\_

Recreational Drug use: Yes [ ] No [ ] Type: \_\_\_\_\_

Females: Any chance you could be pregnant? Yes [ ] No [ ] Date Last Period: \_\_\_\_\_

If the patient is a child, are they in daycare? Yes [ ] No [ ]
If so, how many days per week? \_\_\_\_\_ Child's grade in school: \_\_\_\_\_

SURGERIES

Have you ever had surgery? Yes [ ] No [ ] If yes, complete the following:

Table with 3 columns: Name of Surgical Procedure, Date of Surgery, Surgeon. Multiple rows for listing procedures.

Did you have any complications from surgery? Yes [ ] No [ ] Explain: \_\_\_\_\_
Have you ever been hospitalized other than for surgery? (Include child birth) Yes [ ] No [ ]

Reason \_\_\_\_\_ Date \_\_\_\_\_

MEDICATIONS

List all medications you are taking (with doses):
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

MEDICATION ALLERGIES

List Medication Allergies and Reactions:
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

## SPOKANE CENTER FOR FACIAL PLASTIC SURGERY

- I have no Medical Problems
- I have no Family History of Medical Problems
- No History Available

Please Check the boxes below if you or a relative (Parent or Sibling) have or have had the disease or disorder.

Disease or Disorder	Patient ↓	↓ Parent or Sibling
Heart Disease/Problems		
Chest Pain		
Heart Attack		
High Blood Pressure		
Irregular Heart Beat		
Heart Murmur		
Pacemaker		
Poor Circulation		
High Cholesterol		
Reflux/Heartburn		
Hiatal Hernia		
Bowel Disorder		
I.B.S. ( Irritable Bowel)		
Ulcer		
Hepatitis		
Liver Disorder		
Crohns Disease		
Colitis		
Arthritis		
TMJ		
Fibromyalgia		
Osteoporosis		
Neck/Back Disorder		
Neurological Disease		
Stroke		
Seizure		
Loss of Consciousness		
Multiple Sclerosis (MS)		
Memory Loss		
Headaches		
Alzheimers		
Parkinsons Disease		
Urticaria		
Angioedema/Hives		
Rashes/Lesions		
Lupus		
Hay Fever/Seasonal Allergy		
Glaucoma		

Disease or Disorder	Patient ↓	↓ Parent or Sibling
Cataract		
Macular Degeneration		
Visual Impairment		
Hearing Impairment		
Emphysema/COPD		
Asthma		
Snoring		
Tuberculosis (TB)		
Shortness of Breath		
Sleep Apnea		
Use Oxygen		
Pneumonia		
Bladder Problems		
Kidney Failure/Problems		
Dysuria (Painful Urination)		
Enlarged Prostate		
Polyuria (Frequent Urination)		
Hypoglycemia		
Diabetes		
Thyroid Disorder		
Goiter		
Anemia		
HIV/AIDS		
Bleeding Problems		
Nose Bleeds		
Anxiety		
Depression		
Mental Disease		
Stress		
Recent Life Crisis		
Cancer (List under "Other")		
ADHD		
Autism		
Bipolar Disorder		
Cerebral Palsy		
Dementia		
Down Syndrome		
Anesthetic Problems		

On CPAP?

Are you now taking?:	Y	N
Anticoagulants/Blood thinners		
Anti-Inflammatory Medications		
Aspirin		
Coumadin		
Insulin		

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(OVER)

Patient Name: \_\_\_\_\_

# SPOKANE CENTER FOR FACIAL PLASTIC SURGERY PATIENT INFORMATION

LAST NAME		FIRST		MIDDLE	
SOCIAL SECURITY#		BIRTHDATE		MALE	
FEMALE		MAILING ADDRESS APT		CITY	
STATE		ZIP CODE			
HOME PHONE		WORK PHONE		CELL PHONE	
EMPLOYER		OCCUPATION		REFERRING PHYSICIAN (FIRST AND LAST NAME)	
FAMILY DOCTOR (FIRST AND LAST NAME)					

### SPOUSE'S INFORMATION

SPOUSE'S NAME		SOCIAL SECURITY NUMBER		DATE OF BIRTH	
EMPLOYER		OCCUPATION		WORK PHONE	

### \*\*\*\*\* EMERGENCY CONTACT NOT LIVING WITH THE PATIENT \*\*\*\*\*

NAME		RELATIONSHIP		PHONE NUMBER	
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### COMPLETE IF PATIENT IS A MINOR OR IS COVERED BY A PARENT'S INSURANCE

<u>FATHER</u> OR GUARDIAN LAST NAME		FIRST NAME		SOCIAL SECURITY NUMBER	
DATE OF BIRTH		HOME PHONE		WORK PHONE	
<u>MOTHER</u> OR GUARDIAN LAST NAME		FIRST NAME		SOCIAL SECURITY NUMBER	
DATE OF BIRTH		HOME PHONE		WORK PHONE	

### MEDICAL INSURANCE

INSURANCE COMPANY		ID #		GROUP #	
SUBSCRIBER NAME		SUBSCRIBER SOCIAL SECURITY NUMBER		SUBSCRIBER DATE OF BIRTH	
EMPLOYER		SUBSCRIBER ADDRESS		SUBSCRIBER PHONE	
RELATIONSHIP TO PATIENT					

### SECONDARY MEDICAL INSURANCE

INSURANCE COMPANY		ID #		GROUP #	
SUBSCRIBER NAME		SUBSCRIBER SOCIAL SECURITY NUMBER		SUBSCRIBER DATE OF BIRTH	
EMPLOYER		SUBSCRIBER ADDRESS		SUBSCRIBER PHONE	
RELATIONSHIP TO PATIENT					

WILL THIS CLAIM BE COVERED BY STATE INDUSTRIAL?    YES    NO    NOTIFY RECEPTIONIST PRIOR TO APT. IF YES

I certify that I am the patient or duly authorized general agent of the patient able to furnish the information requested. I acknowledge that the charges incurred by my dependent(s) or me are my responsibility. I acknowledge the 1.5% per month finance charge if my account is not paid in full after 60 days. I also request assignment of insurance benefits to Spokane Ear, Nose & Throat Clinic, P.S. **Deductible and/or copayment are due at the time of service.**

I acknowledge that Spokane Ear, Nose & Throat Clinic reserves the right to charge \$25 for Non-Sufficient Fund Checks, missed appointments or appointments cancelled without 24 hour advance notice.

RESPONSIBLE PARTY SIGNATURE		RELATIONSHIP TO PATIENT		DATE	
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## **IMPORTANT PRIVACY POLICY NOTICE**

At Spokane Ear, Nose & Throat Clinic, we value you as a patient and share your concerns about privacy. To help you understand how we treat your personal information that we obtain from you or other sources in the course of providing you with services, this abbreviated notice describes our use and protection of that information. For a copy of the complete text of this notice, please refer to the end of this page for contact information.

### **The Law requires us to:**

1. keep your medical information private.
2. give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.

### **We have the Right to:**

1. change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

### **Notice of Change to Privacy Practices:**

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

### **USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

We are permitted to use and disclose your medical information without needing your authorization for three purposes:

1. **Treatment**
2. **Payment**
3. **Health Care Operations**

And some very limited specific circumstances detailed in the complete text of this notice.

### **YOUR INDIVIDUAL RIGHTS**

You have the right to:

1. look at or request copies of your medical information.
2. request that we place additional restrictions on our use or disclosure of your medical information.
3. request that we communicate with you about your medical information by different means or to different locations.
4. request that we make changes to your medical information.
5. obtain a copy of this notice for your records.

### **QUESTIONS AND COMPLAINTS**

If you have questions about this notice or want to receive a copy of the complete text, please contact, in writing:

Spokane Ear, Nose & Throat Clinic  
HIPAA Compliance Officer  
217 W Cataldo  
Spokane WA 99201

If you think we may have violated your privacy rights, contact the person named above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

**ACKNOWLEDGEMENT FORM**

I acknowledge I have been given the opportunity to review the Notice of Privacy Practices for Spokane Ear, Nose and Throat Clinic and Columbia Hearing Centers.

Print Name of Patient: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Parent / Guardian

Print Name \_\_\_\_\_  
If Parent or Guardian

**For Office Use Only Below This Line**



Responsible party refused to sign.

\_\_\_\_\_  
Signature of SENT/Columbia Hearing Centers Employee

\_\_\_\_\_  
Print Name of Employee

\_\_\_\_\_  
Date



Spokane Ear, Nose & Throat Clinic, P.S.

Diseases of the  
Ear, Nose & Throat

Sinus & Allergy Care

Sleep Disorders

Snoring Treatment

Hearing Problems

Cochlear Implants

Plastic/Cosmetic Surgery

On-Site Surgery Center

Industrial Claims

Spokane Center for  
Facial Plastic Surgery

Columbia Hearing Center

Inland Northwest  
Foundation  
for Hearing

Karen K. Ahlstrom, MD  
General and Pediatric  
Otolaryngology

Robert A. Bonneau, MD  
Sinus and Allergy  
Sleep Apnea and Snoring

Jeffrey D. Bunn, MD  
Head & Neck Surgery  
General Otolaryngology

Gary E. Cantlon, MD  
Pediatric and General  
Otolaryngology

Jan S. Connelly, MD  
Sinus, Nasal & Allergy  
Disorders

Michael J. Cruz, MD  
Sinus, Nasal & Allergy  
Disorders  
Sleep Apnea & Snoring

Neil A. Giddings, MD  
Otology/Neurotology  
Implantable Hearing Aids

John F. Hoffmann, MD  
Facial Plastic &  
Reconstructive Surgery  
General & Pediatric  
Otolaryngology

David S. Malone, MD  
General Otolaryngology

Neil J. O'Keefe, MD  
Sinus & Allergy  
General Otolaryngology

Michael J. Olds, MD  
Otology/Neurotology  
Pediatric Otology  
Pediatric Cochlear Implants

Al Pokorny, MD  
Sinus & Allergy  
General and Pediatric  
Otolaryngology

Rod J. Emerson  
Administrator

Reviewed:

217 W. Cataldo - Spokane, WA 99201  
5901 N. Mayfair - Spokane, WA 99208

(509) 624-2326  
Fax: (509) 744-3040

## POST-OPERATIVE INSTRUCTIONS Rhinoplasty Surgeries

### Activity- The first week:

- You may carefully clean about the nostrils with a Q-tip and peroxide 3 times per day. Immediately afterwards place a bit of antibiotic ointment (provided) in the nostrils to keep them from drying out. Swelling for at least two weeks will obstruct your nasal passages. A humidifier may help you sleep by allowing you to breathe through your mouth more comfortably.
- Do not blow your nose or sniff excessively as this will only irritate the healing tissues. If you must sneeze, open your mouth. Also, avoid picking up babies or small children; a flailing little arm may strike you in the nose. You probably will hit your nose once or more during the first week. This will hurt but cause no problem unless the force is excessive.
- It is ok to bathe or shower & to get the cast wet.
- Avoid cigarette smoking or even being in the area of excessive smoke as this irritates the nasal tissues and impedes healing.

### Activity – After the first week:

- It takes six weeks for the nasal bones to fully heal. Semi-contact sports are to be avoided for four to six months. Full swimming is allowed after six weeks.
- Do not let your nose become sunburned for six months. This may result in prolonged swelling and erythema (redness).

### Pain, swelling, bruising:

- Most patients complain more from discomfort from nasal and sinus congestion than from pain. Any pain should be controlled via the prescribed medication. After the first day the pain may subside enough so that Advil or plain Tylenol may be sufficient. If not give us a call. Swelling and bruising about the eyes and cheeks is variable. Swelling maximizes at about two days then subsides over the next 5-6 days. Do not worry if you have excess swelling around eyes and cheeks. This will clear completely and not adversely affect the final result. Keep ice pads on eyes until bedtime. Change every 20-30 minutes. This will be beneficial the first 24-48 hours after surgery, for minimizing swelling. Bruising (discoloration) may persist a few days longer. Remember that all these effects subside in time with no bearing on the final result.

### Bleeding:

- It is normal to have some nasal bleeding over the first twelve hours after surgery. It may be necessary to change the gauze drip-pad a dozen or so times over that period. It is normal to have a pinkish-reddish discharge from your nose and throat for the first 3-4 days. This will gradually subside. If you have any profuse nasal bleeding after this time, immediately lie down with your head elevated on three to four pillows. Iced washcloths on the back of the neck and over the eyes may help. Give us a call if these measures do not suffice. If the cast has been removed, forego the finger-on-nose "exercises" until you check with us.

**Nose:**

\* Change the drip pad under your nose as needed (you will not need a drip pad after the packing is removed). After the packing is removed, use a nasal saline mist every 1-2 hours while awake for approximately 2-3 weeks. This non-medicated spray can be obtained at most pharmacies. Using this spray will prevent dryness and crusting of the inside of the nose. Clean your incision with peroxide, and then apply Polysporin ointment to the suture twice a day. Sutures will be removed on postoperative day 3. Avoid contact sports or any nasal trauma for 6 weeks. It is expected that you may need to change your drip pad a dozen times during the first 18 hours postoperatively...if you are concerned with the amount of bleeding, call our office.

**Infection:**

- Infection is unusual after nasal surgery, but occasionally occurs. Fever (over 100 degrees), excessive pain and swelling with redness may signify a developing nasal infection and should be reported. Infections generally clear up quickly with appropriate antibiotic treatment. Itching under the cast may occur and generally is treated with distraction.

**Post-operative visit**

- Sutures are removed and the nose is cleaned three to five days after surgery. These appointments will be made at the time of your pre-op visit. If you do not have them by that time, you should call our office and make these appointments. At seven or eight days after surgery the cast is removed. When the cast is removed the nose will be quite swollen and the nasal tip will be turned up. This will settle down over the next 3-4 days, then more gradually thereafter. Remember that the nose does not assume its final shape until many months after surgery, depending upon the type of nasal skin you have. Your nose will probably look better then prior to the operation within 2-3 weeks, but the final result takes longer; be patient. Occasionally an injection is necessary to reduce swelling in an area. This is relatively painless and done in the weeks following surgery to give you the best possible result.

Any touch up surgery that may be necessary is not done for at least six months. This is usually a small office procedure and no physician's fee is charged. There is a nominal charge for the facility/supplies and anesthesia if sedation is needed.

We hope the above information will help you in the post-operative period. Remember to call on us if you have any questions. Our goal is to give you the best possible care.

I have read, and understand, and reviewed/received a copy of the post-operative instructions as stated above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Any problems please call 624-2326, if after business hours call 458-4468.**

Reviewed:

Revised:



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apt#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Social Security #: \_\_\_\_\_

If client is under age 18, please complete the following:

Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact NOT living with you:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

\_\_\_\_\_  
Client or Parent/Guardian Signature

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Date

The courtesy of 24-hour notice is requested for cancellation of appointments. The failure to cancel three (3) appointments in one year without sufficient notice will be considered cause for termination of services. Out of respect for our other clients, punctual arrival is appreciated. Arrivals that occur 10 minutes past scheduled appointment times could result in forfeiture of appointment.