

BUBOLO MEDICAL

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Hair Patient Questionnaire and History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____ May we contact you via EMail? () YES () NO

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Who may we thank for referring you to our clinic? _____

I want to unlock exclusive offers by subscribing to the monthly newsletter

- Yes
 No

I _____ grant my permission for the use of photographs, videos or case information for the following Bubolo Medical clinical purposes as indicated by my checked box below:

- Allow my picture to be used with identifying information
 Only allow my pictures to be used without identifying who I am
 I do not want any of my photos and or videos used

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Please list all current prescription medications, over the counter medications, and vitamins:

Surgeries, list all and date:

Previous hair transplant type and date:

Medical Conditions:

- High Blood Pressure
- High Cholesterol
- Heart Disease
- Stroke and/or a pulmonary emboli
- Hemochromatosis
- Depression/Anxiety
- Psychiatric Disorder
- Chronic Liver Disease (hepatitis,fatty liver)
- Diabetes
- Thyroid Disease
- Arthritis
- Cancer (type): _____ Year: _____
- HIV
- None of the above**

Please list any other medical condition not listed above:

Allergies? () YES () NO

If Yes, Please explain: _____

List any reactions to medications, drugs, tape, rubber, latex and type of reaction i.e. hives, shock,etc:

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

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PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS FORM INSTRUCTS US WHO ELSE SHOULD GET YOUR MEDICAL INFORMATION. YOUR DOCTORS ARE ALWAYS INFORMED, SO DO NOT LIST THEM.

I authorize Bubolo Medical to disclose my protected health information to:

- **Family member(s)**

Name	Phone Number

- **Non-family members(s)**

Name	Phone Number

- **Myself Only**

I authorize the practice to disclose only the following protected health information to the individual(s) listed above:

- Test results, reports, and general health updates
- Nothing beyond general health questions & updates

I may be contacted with medical information by:

Email Address:
Phone Number:

Expiration or termination of authorization – This authorization will remain in effect until terminated by the patient's personal representative, or another individual or legal entity authorized to do so by a court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy practices, you have the right to revoke or terminate authorization by submitting a written request to our Privacy Director.

By signing below, I acknowledge that I have received, reviewed, understood, and will comply with the policies and procedures explained in the Bubolo Medical Office Policies and Procedures for Patients form.

Patient Signature _____

Date _____

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Office Policies & Procedures For Our Patients

OFFICE HOURS

Our office is available Monday - Thursday 9:00am - 6:00pm and Fridays 9:00am - 1:00pm. We close daily for lunch from 1:00pm - 3:00pm.

APPOINTMENTS & WALK - INS

Bubolo Medical is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow-up due dates.

While we strive to schedule appointments appropriately, emergencies can and do occur in healthcare. We strive to give all of our patients the time they require. For this reason, we kindly request your patience and understanding should delay or rescheduling becomes necessary on your appointment date. We ask that you allow plenty of time to get to the office for your appointment. you may be asked to reschedule your appointment if you are more than 15 minutes late.

We will do our best to provide you with the same - day office visits and accept walk - ins for first available slots for visits. Please let our staff know if you have had any information changes since your last visit. You will be asked to fill out new registration forms annually so we may update your information.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of our patients please be courteous and call Bubolo Medical promptly if you are unable to attend an appointment. This time will be reallocated to another patient who is in need of treatment. This is how we can best serve the needs of all of our patients.

If it is necessary to cancel your scheduled appointment we require that you call one working day in advance. Appointments are in high demand, and your early cancellation will give another patient the ability to have access to timely medical care.

OFFICE CLOSINGS DUE TO WEATHER OR OTHER CIRCUMSTANCES

If our office is closed due to weather conditions or other circumstances beyond our control, the following procedures are used to inform our patients. Closings will be displayed on our website bubolomedical.com and on our Facebook page

- If you are scheduled for an appointment, you will receive a message by telephone.

CONFIDENTIALITY & MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a release of medical information must be completed prior to receipt of these materials. All patients can request a copy of their medical records one time, free of charge. Additional copies may be requested at a cost of \$0.75 per page. The law allows Medical Offices 30 days to complete requests for records.