ONLINE CONSULTATION

ANGELA KEEN,M.D.
Plastic Surgery & Skin Care

CONTACT INFORMATION

Name	Date Of Birth	Age	Sex
Address	City	State	Zip
Preferred Phone #	Alternate Phone		
Email Address	Preferred Contact Method		
Reason For Consult	How Did You Hear About Our Practice?		
Hobbies/Work	Does Anyone Live With You? If So, Who?		
Insurance Company	Insurance Id #		
Emergency Contact	Emergency Contact Phone #		

RESPONSIBLE PARTY IF UNDER 18...

Name	Relation		
Address *(if different from above)*	City	State	Zip
Preferred Phone	Alternate Phone		

GENERAL PERMIT FOR PROFESSIONAL CARE AND PHOTOGRAPHS: I hereby give permission to Dr. Angela Keen, MD and associates to render treatment as she/he sees fit upon myself or my dependent and to call any consultant or anesthesiologist, laboratory, personnel, etc., as is deemed advisable in the care of this case. I also agree to be responsible for their charges, as well as the surgeon's, hospital's and/or surgical centers' charges. I understand that photographs before and after surgery are standard of care and I agree to complete this process. I understand photographs may be used for patient education as well as quality assurance purposes. I am advised that though good results are expected, they are not guaranteed.

Patient's or Parent's Signature:_____**Date**:_____

ANGELA KEEN, M.D. **Plastic Surgery & Skin Care | Certified By The American Board Of Plastic Surgery**
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PATIENT INFORMATION

ANGELA KEEN,M.D.
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Name:_____ **Date**:_____

SKIN	YES	NO	GENERAL	YES	NO	HEAD AND NECK	YES	NO
NEW OR CHANGING LESIONS	○	◉	UNEXPLAINED WEIGHT CHANGE	○	◉	DIFFICULT BREATHING THROUGH NOSE	○	◉
HISTORY OF SKIN CANCER	○	◉	FATIGUE	○	◉	EYE PAIN	○	◉
HEMATOLOGIC	YES	NO	PERSONAL HISTORY OF CANCER	○	◉	GLAUCOMA	○	◉
ABNORMAL BLEEDING/BRUISING	○	◉	DIABETES	○	○	EXCESSIVE TEARING	○	◉
ANEMIA	○	◉	LIVER DISEASE OR HEPATITIS	○	◉	DRY EYES	○	◉
IMMUNOLOGIC	YES	NO	CARDIOVASCULAR	YES	NO	PULMONARY	YES	NO
HIV	○	◉	HIGH BLOOD PRESSURE	○	◉	ASTHMA	○	◉
LUPUS	○	◉	CHEST PAIN	○	◉	CHRONIC RESPIRATORY PROBLEMS	○	◉
OTHER AUTOIMMUNE DISEASE	○	◉	SHORTNESS OF BREATHE	○	◉	ENDOCRINE	YES	NO
PSYCHIATRIC	YES	NO	IRREGULAR HEARTBEAT	○	◉	DIABETES	○	○
DEPRESSION	○	◉	HISTORY OF HEART DISEASE	○	◉	THYROID ABNORMALITIES	○	◉
ANXIETY	○	◉	HISTORY OF BLOOD CLOT	○	◉	NEUROLOGICAL	YES	NO
						SEIZURES	○	◉
						STROKE	○	◉

PLEASE DETAIL ANY "YES" ANSWERS ABOVE AND LIST ANY ADDITIONAL PROBLEMS OR CONCERNS:

Do you have any allergies or reactions to medications? Yes_____ No_____ If yes, please list: _____

Number of child births?_____ Last Mammogram?_____Do you smoke? Yes_____ No_____

Please list any prescription medications currently being taken: _____

Please list any herbs and/or vitamins currently being taken: _____

Please list all prior surgeries including cosmetic procedures: _____

Please list your top 3 priorities for Dr. Keen to discuss with you: _____

Notes

TELEHEALTH AUTHORIZATION AND RELEASE

ANGELA KEEN,M.D.
Plastic Surgery & Skin Care

I hereby consent to communicating online with Dr.Keen and his/her staff and personnel (hereinafter referred to collectively as "my Doctor") so as to conduct virtual consultations, telemedicine/telehealth, and any other purpose deemed by my Doctor to be appropriate while I am receiving medical and aesthetic services.

As announced by the US Department of Health & Human Services ("HHS") on March 17, 2020, I understand my Doctor is now authorized to use non-public facing audio and/or video communication technology to provide telehealth, whether or not related to COVID-19, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, but my Doctor is not authorized to use public facing technology, such as Facebook Live, Twitch or TikTok.

I accept that even authorized non-public facing third-party applications potentially introduce privacy risks, but my Doctor will enable all available encryption and privacy modes when using these applications.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. Unless and until I revoke this authorization, it will exist in perpetuity from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from my Doctor.

I release and discharge my Doctor and all parties acting under my Doctor's license and authority from any telehealth medical privacy claims I might otherwise have had prior to HHS's March 17, 2020 notification. I certify that I have read this Authorization and Release and fully understand its terms.

_____ _____

Patient Signature **Witness/Physician/Staff**

_____ _____

Patient Name **Date**

I have read the above Authorization and Release. I am the parent, guardian or conservator of the patient, a minor. I am authorized to sign this consent on the patient's behalf.

_____ _____

Parent/Guardian/Conservator Signature **Date**

_____

Parent/Guardian/Conservator Name

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