Andres Bustillo, MD
Facial Plastic & Reconstructive Surgery
www.drbustillo.com

Physician Biography

Dr. Andres Bustillo is passionate about quality patient care and excellence in facial plastic surgery. His signature look is one that is conservative and natural in appearance.
Andres Bustillo, MD is a facial plastic & reconstructive surgeon. He completed a five year residency in otolaryngology-head and neck surgery at the University of Miami - Jackson Memorial Hospital in Miami. He then went on to complete a one year fellowship in facial plastic & reconstructive surgery at New York University in New York City.

Abbreviated Curriculum Vitea

Board Certification
Diplomate, American Board of Facial Plastic & Reconstructive Surgery
Diplomate, American Board of Otolaryngology – Head & Neck Surgery

Graduate Medical Education
Facial Plastic & Reconstructive Surgery Fellowship : New York University School of Medicine

Otolaryngology – Head & Neck Surgery Residency : University of Miami School of Medicine

General Surgery Internship : University of Miami School of Medicine

Education
University of Miami School of Medicine : Doctor of Medicine
Boston University : B.A. in Biology
Belen Jesuit Preparatory School : High School

Publications

Book Chapters

Pastorek N, Bustillo A. The deep plane face lift.
In: Facial Plastic Surgery Clinics. Wang T. (ed)
W.B. Saunders. Philadelphia, PA. Vol. 13 (3) August 2005.

Pastorek N, Bustillo A. Blepharoplasty.
In: Masters of Facial Plastic Surgery. Johnson CM. (ed)
W.B. Saunders. Philadelphia, PA. In Print.

Pastorek N, Bustillo A. Blepharoplasty.
In: Otolaryngology - Head and Neck Surgery. Fourth Edition. Bailey B. (ed)
Lippincott, Williams, & Wilkins. Philadelphia, PA. In Print.

Constantinides MS, Bustillo A. Anatomy and analysis in revision rhinoplasty.
In: Revision Rhinoplasty. Becker DG. (ed)
Thieme Medical Publishers, N.Y. In Print.

Miller PJ, Bustillo A. Complications of the augmented dorsum in revision rhinoplasty.
In: Revision Rhinoplasty. Becker DG. (ed)
Thieme Medical Publishers, N.Y. In Print.

Peer Reviewed Journals

The extended columellar strut tip graft.
Pastorek N, Bustillo A, Murphy M, Becker DG.
Archives of Facial Plastic Surgery 2005 May-Jun;7(3):176-84.

Caudal Septoplasty for Treatment of Septal Deviation: Aesthetic and Functional Correction of the Nasal Base.
Sedwick J, Bustillo A, Simons RL.
Archives of Facial Plastic Surgery 2005 May-Jun;7(3):158-162.

Nasal valve surgery improves disease-specific quality of life.
Rhee JS, Poetker DM, Smith TL, Bustillo A, Burzynski M, Davis RE.
The Laryngoscope 2005 Mar; 115(3): 437-41.

8940 N. Kendall Dr.
SUITE 504 E-2
Miami, Fl 33176

SOUTH FLORIDA FACIAL PLASTIC SURGERY

TEL (305) 663-3380
FAX (305) 274-6766

Name: ____ Today's Date: _________________________

In which area are you considering surgery:

Nose: __________ *Face/Neck*: __________ *Eyes*:__________ *Ears*:_____________ *Chin*: ___________

Botox: __________ *Restylane/Juviderm*: ___________ *Radiesse*: __________ *Sculptra*: _____________

Chemical Peel: ___________ *Moles,Cyst*: __________ *Scars*: _________ *Cancer Reconstruction*: ________

Other: _______________________

Who referred you to Dr. Bustillo ? ____

What would you specifically like corrected? ____

Have you spoken with any friends or relatives who have had cosmetic surgery? ___________________________

How long have you thought about surgery? ____

Do you feel ready now? ____

How would your life change from an improved appearance? ____

Have you consulted other doctors about this surgery? ____

When:____

Have you had cosmetic surgery in the past? ____________ When: _____________________________________

What procedures were performed?____

Name of the doctor: _____________________________________ Good experience? _____________________

Satisfactory results? ____

Have you had any Facial, Nose or Eyes injuries? ____

Describe: ____

Have you ever had silicone or biopolymer injections ? ____

I understand that the above answers are important for my safety. I therefore certify that all of the above answers are true and correct to the best of my knowledge.

Signed: ____ Date: ___________________

8940 N. Kendall Dr.
SUITE 504 E-2
Miami, Fl 33176

SOUTH FLORIDA FACIAL PLASTIC SURGERY

TEL (305) 663-3380
FAX (305) 274-6766

Medical History

Name : ______________________________ Sex: __________ Age: ________________

Family Physician: ____

Physician's Address: ____

Last Examination: __________________ Last Menstrual Period: ________________________

Are you pregnant ? _________ YES __________ NO

List all hospitalizations and year: ____________________________________

Have you had any serious illness ? ____________________________________

List any medications you are currently taking or have taken in the past year: ____________________

____

Have you or does any family member have a history of a bleeding disorder? ____________________

Have you or does any family member have a history of complications with anesthesia ? ______________

Have you ever had:

Abnormal Bleeding or Bruising	*Yes*	*No*	*Paralysis Weakness*	*Yes*	*No*
Nasal Allergy	*Yes*	*No*	*Seizures*	*Yes*	*No*
Eye Problems	*Yes*	*No*	*Anemia*	*Yes*	*No*
Hormone, Thyroid Problems	*Yes*	*No*	*Heart Trouble, Murmur*	*Yes*	*No*
Chest Pain			*Mitral Valve Prolapse*		
High Blood Pressure	*Yes*	*No*	*Asthma*	*Yes*	*No*
Stomach Trouble	*Yes*	*No*	*Recreational Drugs*	*Yes*	*No*
Jaundice	*Yes*	*No*	*Psychiatric Care*	*Yes*	*No*
Arthritis	*Yes*	*No*	*Gyn Problems*	*Yes*	*No*
Skin Disease or Infection			*Prostate Problems*		
Are you Easily Depressed ?	*Yes*	*No*	*Headaches, Dizziness*	*Yes*	*No*
Diabetes	*Yes*	*No*	*Herpes (cold sores)*	*Yes*	*No*

Have you ever tested positive for:

Hepatitis (types A, B, or C)	*Yes*	*No*	*Venereal Disease*	*Yes*	*No*
HIV (AIDS)	*Yes*	*No*	*Tuberculosis*	*Yes*	*No*

Have you ever had an adverse reaction to novacaine or xylocaine ? ________________________

List any medication to which you have had an adverse reaction. __________________________

Are you allergic to latex products ? ____________________________________

Do you usually drink more than 2 alcoholic beverages? ______________________________

Do you smoke ? ______ YES _______ NO Number of packs per day ? ____________________

Do you have other medical problems that have not been covered ? ______________________

Explain. ____

____

I understand that the above answers are important for my safety. I therefore certify that all of the above answers are true and correct to the best of my knowledge. I also give Dr. Bustillo permission to contact my physician for any information concerning my medical history.

Signed: ______________________________ Date: ______________

SOUTH FLORIDA FACIAL PLASTIC SURGERY

PATIENT INFORMATION SHEET

OFFICE USE ONLY:
IDX #: ___________________________
CHART #: ______________________

Today's date: ___/ ____/ _______

Patient's name: ____ S.S. #: __________________________________
(Last) (First) (M.I.)

Address: ____ Zip Code: ______________________
(Number) (Street) (City) (State)

Email: ____

Date of Birth: ____/ ____/ __________ Place of Birth: __________________________ Marital Status: __________________

Home Phone: (____) _______________ Cell Phone: (___) _____________________ Occupation: ______________________

Employer: ____ Work Phone: (____) _________________

Name of Spouse or Parent / Guardian: ____

Spouse's or Parent's / Guardian's Employer: _____________________________ Work Phone: (____) _________________

In Case of Emergency Notify: ____ Telephone: (____) ___________________

Relationship to You: ____

Method of Payment at Time of Visit: ________ Cash ________ Check ________ Visa/M.C.

South Florida Facial Plastic Surgery (SFENTA, PA)

Patient Acknowledgement of Receipt of the Notice of Privacy Practices

and Consent to Use and Disclose Health Information

I acknowledge that I was provided with a copy of the SFENTA, P.A.'s Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that SFENTA, P.A. continues to its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my Health Information for the purposes and the activities permitted under the federal privacy law.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the SFENTA, P.A Corporate office at (305) 558-3724.

I acknowledge that I have received a copy of the SFENTA, P.A. Notice of Privacy Practices.

Patient Name: ____ **Date:** ________________

Signature of Patient: ______________________________________

Patient Legal Representative (if applicable): ________________________________ **Date:** _________________

Signature of Legal Representative (if applicable): ____________________________ **Date:** _________________

FOR PHYSICIAN'S OFFICE USE ONLY

Office Staff Member Obtaining Signature: ____

Reason Signature and Date were not obtained
D Individual Refused to Sign
D Communication barriers prohibited obtaining the acknowledgement
D An emergency situation prevented us from obtaining acknowledgement
D Other (Please specify)

South Florida Facial Plastic Surgery (SFENTA, PA)

Designation of Personal Representative

As required by the Health Information Portability and Accountability Act of 1996, you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Patient Name: ____ Date: ___/ ___/ ________
(Last) (First) (MI)

Address: ____

Telephone: (___) ____________________________ Date of Birth: ___/ ___/ ______

I request the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my protected health information:

Name: _______________________________________

Address: ____

Telephone (___) ____________________________

What relationship is this person to you?: ____

This person is to be afforded all the privileges that would be afforded to me with respect to my protected health information.

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to South Florida Facial Plastic Surgery. I further understand that any such revocation does not apply if that person or person's authorized use or disclosure of my protected health information have already taken action on my behalf.

Patient's Signature: _________________________________ Date: ___/ ___/ ______

I hereby revoke this designation of a personal representative.

Patient's Signature: _________________________________ Date: ___/ ___/ ______