

**ANDRES BUSTILLO, M.D., F.A.C.S.**  
FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

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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.

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**EDUCATION & CERTIFICATION**

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**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, **Bachelor of Arts in Biology.**  
Belen Jesuit Preparatory School

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**PUBLICATIONS**

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**Book Chapters**

Pastorek, Norman and Andres Bustillo. “The deep plane face lift.” *Facial Plastic Surgery Clinics* Vol. 13. Ed. Wang T. and W.B. Saunders. Philadelphia, PA, August 2005. Print.

Pastorek, Norman and Andres Bustillo. “Blepharoplasty.” *Masters of Facial Plastic Surgery*. Ed. Johnson CM. and W.B. Saunders. Philadelphia, PA. Print.

Pastorek, Norman and Andres Bustillo. “Blepharoplasty.” *Otolaryngology - Head and Neck Surgery*. 4<sup>th</sup> ed. Bailey B. (ed) Lippincott, Williams, & Wilkins. Philadelphia, PA. Print.

Constantinides, MS and Andres Bustillo. “Anatomy and analysis in revision rhinoplasty.” *Revision Rhinoplasty*. Becker DG. (ed) Thieme Medical Publishers, N.Y. Print.

Miller PJ, and Andres Bustillo. “Complications of the augmented dorsum in revision rhinoplasty.” *Revision Rhinoplasty*. Becker DG. (ed) Thieme Medical Publishers, N.Y. Print.

**Peer Reviewed Journals**

Pastorek, Norman and Andres Bustillo. “The extended columellar strut tip graft.” *Archives of Facial Plastic Surgery*. 2005 May-Jun;7(3):176-84.

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

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

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

In which area are you considering surgery and/or treatment:

Nose:	
Eyes:	
Ears:	

Face/Neck:	
Chin:	
Cheek Bones:	

Moles/Cyst:	
Chemical Peel:	
Scar Revision:	

Botox/Dysport:	
Fillers (Restylane, Perlane, Juvederm, Radiesse, Sculptra):	
Skin 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? Yes  No

How long have you thought about surgery? \_\_\_\_\_

Do you feel ready now? Yes  No

How will your life change from an improved appearance? \_\_\_\_\_

Have you consulted other doctors about this surgery? \_\_\_\_\_

When? \_\_\_\_\_

Have you had cosmetic surgery in the past? Yes  No  When? \_\_\_\_\_

What procedures were performed? \_\_\_\_\_

Name of doctor: \_\_\_\_\_ Good experience? \_\_\_\_\_

Satisfactory results? \_\_\_\_\_

Have you had any Facial, Nose, or Eye injuries? \_\_\_\_\_

Describe: \_\_\_\_\_

Have you ever had silicone or biopolymer injections? \_\_\_\_\_

# PATIENT INFORMATION SHEET

Patient's Name: \_\_\_\_\_ S.S.# \_\_\_\_\_

Address: \_\_\_\_\_

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

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Preferred Contact Method: E-Mail: \_\_\_\_\_ Mobile/Text: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Spouse or Parent/Guardian: \_\_\_\_\_

Spouse or Parent's/Guardian's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

In Case of Emergency Notify: \_\_\_\_\_ Telephone: \_\_\_\_\_

Relationship to You: \_\_\_\_\_

## MEDICAL HISTORY

Check the appropriate answer. If you do not know the correct answer, please write "DON'T KNOW" on the line provided.

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Are you currently under a physician's care? \_\_\_\_\_ No  Yes

Since When? \_\_\_\_\_ Why? \_\_\_\_\_

When was your last complete physical exam? \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Are you currently under a physician's care? (If **Yes**, please list) \_\_\_\_\_ No  Yes

Are you taking any medications or substances? (If **Yes**, please list) \_\_\_\_\_ No  Yes

Are you allergic to any medications or substances? (If **Yes**, please list) \_\_\_\_\_ No  Yes

Do you have any other allergies? (If **Yes**, please list) \_\_\_\_\_ No  Yes

Do you have any problems with penicillin, antibiotics, local anesthetics, or other medications? \_\_\_\_\_ No  Yes

List all surgeries that you have had in the past and date. \_\_\_\_\_

Have you or a family member ever had any complications with anesthesia? \_\_\_\_\_ No  Yes

Are you allergic to latex? \_\_\_\_\_ No  Yes

Are you pregnant or suspect you may be? \_\_\_\_\_ No  Yes

Do you use birth control medications? \_\_\_\_\_ No  Yes

Have you ever been treated for or been told you may have heart disease? \_\_\_\_\_ No  Yes

Have you ever taken the pill PHEN-FEN? \_\_\_\_\_ No  Yes

Have you used or plan on taking ACUTANE? \_\_\_\_\_ No  Yes

Do you have a pacemaker or an artificial heart valve implant? \_\_\_\_\_ No  Yes

Have you ever had rheumatic fever? \_\_\_\_\_ No  Yes

Are you aware of any heart murmurs or irregular heart beats (arrhythmia)? \_\_\_\_\_ No  Yes

Do you have chest pain? \_\_\_\_\_ No  Yes

Do you have low or high blood pressure? \_\_\_\_\_ No  Yes

Have you had a serious illness or previous surgery? *(If Yes, please list)* \_\_\_\_\_ No  Yes

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Have you ever had any radiation or chemo treatment for tumor growth? \_\_\_\_\_ No  Yes

Do you have inflammatory arthritis or rheumatism? \_\_\_\_\_ No  Yes

Do you have artificial joints or prosthesis? \_\_\_\_\_ No  Yes

Do you have any blood disorders such as anemia, leukemia, etc? \_\_\_\_\_ No  Yes

Have you ever bleed excessively after being cut or injured? \_\_\_\_\_ No  Yes

Do you have any stomach problems? \_\_\_\_\_ No  Yes

Do you have any kidney or urinary tract problems? \_\_\_\_\_ No  Yes

Do you have any liver problems? \_\_\_\_\_ No  Yes

Are you diabetic? \_\_\_\_\_ No  Yes

Do you have asthma or another respiratory condition? \_\_\_\_\_ No  Yes

Do you have a history of sleep apnea? \_\_\_\_\_ No  Yes

Do you have epilepsy or seizure disorders? \_\_\_\_\_ No  Yes

Are you HIV positive? \_\_\_\_\_ No  Yes

Have you had or do you test positive for hepatitis? \_\_\_\_\_ No  Yes

Do you have or have you had TB (Tuberculosis)? \_\_\_\_\_ No  Yes

Do you smoke cigarettes or cigars? *(If Yes, how much)* \_\_\_\_\_ No  Yes

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Do you consume alcoholic beverages? *(If Yes, how much)* \_\_\_\_\_ No  Yes

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Do you habitually use marijuana, cocaine, or other substance? \_\_\_\_\_ No  Yes

Do you have eye conditions, double vision, or glaucoma? \_\_\_\_\_ No  Yes

Do you have a dental condition? \_\_\_\_\_ No  Yes

Do you have a neurological condition, seizures, or migraines? \_\_\_\_\_ No  Yes

Have you had psychiatric treatment? \_\_\_\_\_ No  Yes

Do you have any disease, condition or problem not listed? *(If Yes, please list)* \_\_\_\_\_ No  Yes

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Have you ever had any radiation or chemo treatment for tumor growth? \_\_\_\_\_ No  Yes

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE**

Patient/Guardian's Signature: \_\_\_\_\_ Date: «Date»

**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) 667-4515.**

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

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Patient Legal Representative (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Legal Representative (if applicable): \_\_\_\_\_

FOR PHYSICIAN'S OFFICE USE ONLY

Office Staff Member Obtaining Signature: \_\_\_\_\_

Reason Signature and Date were not obtained

- Individual Refused to Sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_

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**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's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

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

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: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

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 **SFENTA, P.A., 6705 Red Rd, Ste 600, Coral Gables, FL 33143**. 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: \_\_\_\_\_