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

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andres@drbustillo.com

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.

EDUCATION & CERTIFICATION

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

PUBLICATIONS

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*. 4th ed. Bailey B. (ed) Lippincott, Williams, & Wilkins. Philadelphia, PA. Print.

Constantinides, MS and Andres Bustillo. "Anatomy and analysis in revision rhinoplasty." *Revision Rhinoplas*ty. 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:		Face/Neck:		Moles/Cyst:		Botox/Dysport:	
Eyes:		Chin:		Chemical Peel:		Fillers (Restylane, Perlane, Juvederm, Radiesse, Sculptra):	
Ears:		Cheek Bones:		Scar Revision:		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	☐

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	☐

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

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	☐

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: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

Insured's Name: _____ D.O.B.: ___/___/___ HMO ____ PPO ____ POS ____

Insured's S.S.#: ___-___-___ Insured's Relationship to Patient: _____

Policy Number: _____ Group Number: _____

If the policy is through work, please complete the following:

Insured's Employer Name: _____

SECONDARY INSURANCE COMPANY NAME: _____

Insured's Name: _____ D.O.B.: ___/___/___ HMO ____ PPO ____ POS ____

Insured's S.S.#: ___-___-___ Insured's Relationship to Patient: _____

Policy Number: _____ Group Number: _____

FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY OFFICE VISIT OR PROCEDURES RENDERED BY MY DOCTOR & SFENTA, PA, THAT MY INSURANCE COMPANY DEEMS NOT A COVERED SERVICE UNDER MY POLICY.

Signature: _____ Date: _____

AUTHORIZATION / RELEASE

- □ AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any information to my insurance company for the processing of my claims made on the behalf of these services.
- □ AUTHORIZATION FOR ASSIGNMENT OF BENEFITS: I hereby authorize my insurance company to issue payment directly to the physician on my behalf for pending claim(s) due to services rendered to **(Name of Patient)** _____ Relationship to Insured: _____
- □ AUTHORIZATION TO RELEASE INFORMATION TO OTHER PHYSICIAN: I hereby authorize the release of my medical information to my primary care physician: **(Name of Doctor)** _____

Signature: _____ Date: _____

Advance Notice of Possible Non-Covered Services Form
NOTE: You need to make a choice about receiving these Health Care items or services.

Patient's Name: _____

Date: _____ Insurance Plan: _____

The fact that your insurance carrier may not cover a service does not mean that you should not receive the service. There is a medical reason for why your physician recommended said service(s). The purpose of this form is to help you make an informed choice about whether or not, to receive said service(s) understanding that you may have to pay for this yourself. Please read this information in its entirety prior to signing.

- You are encouraged to contact your insurance plan directly prior to services being rendered if you have any questions regarding these/this service(s).

It is the patient's responsibility to obtain verification of their insurance plan benefits. ***Verbal or On-line verification*** is **NOT** a guarantee of payment. Services are subject to the limitations and exclusions including pre-existing conditions as stated in the insurance benefit plan.
I understand that in the event my insurance determines a service does not meet their definition of medical necessity or is considered a non-covered service due to plan exclusions and limitations including pre-existing conditions, I will be financially responsible for payment of these service(s).

Diagnostic imaging services scheduled by our office at an outside facility

Our office makes every attempt to schedule ALL diagnostic testing at a facility that is participating with our insurance plan. However, due to the constant addition and termination of plan affiliations it is the patient's responsibility to confirm facility participation prior to receiving services.

I acknowledge that the office has provided me with a copy of this disclosure and understand the contents.

Patient/Insured's Signature: _____ 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)_____

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: _____