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

Elected by his peers for inclusion in Best Doctors in America® from 2011 to 2012.

PUBLICATIONS

Book Chapters


Peer Reviewed Journals


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: _____ 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: ___________________________ Physician Phone: __________________________
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 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 □
Do you have a family history of unexpected death(s) following general anesthesia or exercise? ______ No □ Yes □
Do you have a family or personal history of malignant hyperthermia? ______ No □ Yes □
Do you have a family or personal history of muscle or neuromuscular disorder?  

- [ ] No  
- [x] Yes  

Do you have a family or personal history of high temperature following exercise?  

- [ ] No  
- [x] Yes  

Do you have a personal history of muscle spasm?  

- [ ] No  
- [x] Yes  

Do you have a family or personal history of dark/chocolate colored urine or unanticipated fever immediately following anesthesia or serious exercise?  

- [ ] No  
- [x] Yes  

Are you allergic to latex?  

- [ ] No  
- [x] Yes  

Are you pregnant or suspect you may be?  

- [ ] No  
- [x] Yes  

Do you use birth control medications?  

- [ ] No  
- [x] Yes  

Have you ever been treated for or been told you may have heart disease?  

- [ ] No  
- [x] Yes  

Have you ever taken the pill PHEN-FEN?  

- [ ] No  
- [x] Yes  

Have you used or plan on taking ACUTANE?  

- [ ] No  
- [x] Yes  

Have you ever had rheumatic fever?  

- [ ] No  
- [x] Yes  

Are you aware of any heart murmurs or irregular heart beats (arrhythmia)?  

- [ ] No  
- [x] Yes  

Do you have chest pain?  

- [ ] No  
- [x] Yes  

Do you have low or high blood pressure?  

- [ ] No  
- [x] Yes  

Have you had a serious illness or previous surgery? (If Yes, please list)  

- [ ] No  
- [x] Yes  

Have you ever had any radiation or chemo treatment for tumor growth?  

- [ ] No  
- [x] Yes  

Do you have inflammatory arthritis or rheumatism?  

- [ ] No  
- [x] Yes  

Do you have artificial joints or prosthesis?  

- [ ] No  
- [x] Yes  

Do you have any blood disorders such as anemia, leukemia, etc?  

- [ ] No  
- [x] Yes  

Have you ever bled excessively after being cut or injured?  

- [ ] No  
- [x] Yes  

Do you have any stomach problems?  

- [ ] No  
- [x] Yes  

Do you have any kidney or urinary tract problems?  

- [ ] No  
- [x] Yes  

Do you have any liver problems?  

- [ ] No  
- [x] Yes  

Are you diabetic?  

- [ ] No  
- [x] Yes  

Do you have asthma or another respiratory condition?  

- [ ] No  
- [x] Yes  

Do you have a history of sleep apnea?  

- [ ] No  
- [x] Yes  

Do you have epilepsy, seizure disorders, or a neurological condition?  

- [ ] No  
- [x] Yes  

Are you HIV positive?  

- [ ] No  
- [x] Yes  

Have you had or do you test positive for hepatitis?  

- [ ] No  
- [x] Yes  

Do you have or have you had TB (Tuberculosis)?  

- [ ] No  
- [x] Yes  

Do you smoke cigarettes or cigars? (If Yes, how much)  

- [ ] No  
- [x] Yes  

Do you consume alcoholic beverages? (If Yes, how much)  

- [ ] No  
- [x] Yes  

Do you habitually use marijuana, cocaine, or other substance?  

- [ ] No  
- [x] Yes  

Do you have eye conditions, double vision, or glaucoma?  

- [ ] No  
- [x] Yes  

Have you had psychiatric treatment? (If Yes, please list)  

- [ ] No  
- [x] Yes  

Do you have any disease, condition or problem not listed? (If Yes, please list)  

- [ ] No  
- [x] Yes  

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

Patient/Guardian’s Signature: ____________________________ Date: ____________________________
Patient’s Name: ________________________________ Date: __________________

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

- Nose:
- Eyes:
- Face/Neck:
- Chin:
- Ears:
- Cheek Bones:
- Moles/Cyst:
- Chemical Peel:
- Botox/Dysport:
- Fillers (Restylane, Perlane, Juvederm, Radiesse, Sculptra):
- Chemical Peel:
- 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 ☐

When are you planning on having the surgery performed? __________________________________________________________________

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? ____________________________________________________________________
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: ________________