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.

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

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 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 INFORMATION SHEET

Patient's Name:		S.S.‡	<i></i>		
Address:					
City:	State:	Zip Code:			
Email:					
Date of Birth:		Marita			
Mobile Phone:	Home Phone:	Work Phone:			
Preferred Contact Method: E-Mail:	Mobile/	Work Phone:			
Employer:		Occupation:			
Name of Spouse or Parent/Guardian:					
Spouse or Parent's/Guardian's Employ	/er:	Work Pho	ne:		
In Case of Emergency Notify:		Telephone			
Check the appropriate answer. If you do Physician's Name:		wer, please write "DON'T KN Physician Phone:		·	ed.
Are you currently under a physician's care'				☐ Yes	
		Why?			
When was your last complete physical exa					
Age: Height:					
Are you taking any medications or substan			No	☐ Yes	
Are you allergic to any medications or subs	stances? (If Yes , please li	st)	No	☐ Yes	
Do you have any other allergies? (If Yes, p	olease list)		No No	☐ Yes	
Do you have any problems with penicillin, a	antibiotics, local anesthetic	cs, or other medications?	No	☐ Yes	
List all surgeries that you have had in the p	east and date.				
Have you or a family member ever had any	complications with anest	hesia?	No	☐ Yes	
Do you have a family or personal history of			No No	☐ Yes	_
LIO VOU DAVE A family of Dersonal history of	manduant nyperthermia?		Nο	LI YAS	ப

Do you have a family or personal history of muscle or neuromuscular disorder?	No	ш	Yes	L
Do you have a family or personal history of high temperature following exercise?	No		Yes	
Do you have a personal history of muscle spasm?	No		Yes	
Do you have a family or personal history of dark/chocolate colored urine or unanticipated for	ever			
mmediately following anesthesia or serious exercise?	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?			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?	NI-		Yes	
Have you had a serious illness or previous surgery? (If Yes, please list)	No No		Yes	
Have you ever had any radiation or chemo treatment for tumor growth?	No		Yes	
		_	Yes	
		_	Yes	
Davis have any bland disorders such as a partial laukarria, ata?	Na	_	Yes	
			Yes	
		_	Yes	
		_	Yes	
Do you have any kidney or urinary tract problems?		_	Yes	_
Oo you have any liver problems?		_	Yes	
Are you diabetic?	No	_	Yes	
Do you have asthma or another respiratory condition?		_		
Do you have a history of sleep apnea?		_	Yes Yes	
Do you have epilepsy, seizure disorders, or a neurological condition? Are you HIV positive?	No		Yes	
	No No	_		
Have you had or do you test positive for hepatitis?			Yes Yes	
Do you have or have you had TB (Tuberculosis)? Do you smoke cigarettes or cigars? (If Yes , how much)			Yes	
Do you consume alcoholic beverages? (If Yes, how much)	No No		Yes	
Do you habitually use marijuana, cocaine, or other substance?	No		Yes	
Do you have eye conditions, double vision, or glaucoma?			Yes	
Do you have a dental condition?			Yes	
Have you had psychiatric treatment?			Yes	
Do you have any disease, condition or problem not listed? (If Yes , please list)			Yes	Г

Patient's Name:			Date:		
In which area are	you considering surgery a	nd/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 s	pecifically like corrected?				
Have you spoken	with any friends or relative	s who have had cosmetic	surgery? Yes □ No □		
How long have yo	ou thought about surgery?				
Do you feel ready now? Yes □ No □					
When are you pla	nning on having the surger	ry 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: G		Good experience?	Good experience?		
Satisfactory result	s?				
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 acknowledgem An emergency situation prevented us from obtaining acknowledgem Other (Please Specify)	ent gement
Designation of Personal	Representative
As required by the Health Information Portability and Accourance or more persons to act on your behalf with respect to the you. By completing this form you are informing us of your was personal representative. You may revoke this designation a your copy of this form and returning it to this office.	ne protection of health information that pertains to ish to designate the named person as your
Patient's Name:	Date:
Address:	
City: State:	·
Telephone: Date of	Birth:
I request the following person to act as my personal represe use and/or disclosure of my protected health information:	entative with respect to decisions involving the
Name:	Telephone:
Address:	
This person is to be afforded all the privileges that wou protected health information. I understand that I may revoke this designation at any time this form and returning it to SFENTA, P.A., 6705 Red Rd, S understand that any such revocation does not apply if that p my protected health information have already taken action of	by signing the revocation section of my copy of Ste 600, Coral Gables, FL 33143. I further person or person's authorized use or disclosure of
Patient's Signature:	Date:
I hereby revoke this designation of a personal represen	tative.