ADMIRE

PLASTIC SURGERY

# PATIENT INFORMATION FORM

Today's date: ________________________

PATIENT'S NAME

(Last)________________________________ (First) ________________________________ (M.I.) __________

ADDRESS________________________________________CITY________________STATE_______ZIP____________

HOME PHONE _____________________________________ CELL ________________________________________

DATE OF BIRTH_____________________________________ AGE______________ GENDER________________

SOCIAL SECURITY #__________________________________ MARITAL STATUS _________________________

EMPLOYER________________________________________________________________________________

(Name) (Address) (City/St/Zip)

OCCUPATION_______________________ WORK PHONE _______________ MAY WE CONTACT YOU AT WORK? Y N

WHO IS YOUR PRIMARY CARE PHYSICIAN? _______________________________________________

WHO REFFERED YOU/HOW DID YOU HEAR ABOUT DR. ADMIRE?_____________________________

MAY WE CONTACT YOU BY EMAIL? YES NO EMAIL ADDRESS:______________________________

WHAT IS THE NATURE OF THIS VISIT? __________________________________________________

PARENT/GARDIAN/SPOUSE

(Last)________________________________ (First) ________________________________ (M.I.) ____________

ADDRESS ________________________________________ CITY ______________STATE______ZIP______________

HOME PHONE _____________________________________ CELL__________________________________________

DATE OF BIRTH___________________________________ AGE______________ GENDER____________________

SOCIAL SECURITY #______________________________________ MARITAL STATUS________________________

PIMARY MEDICAL INSURANCE (If non-cosmetic)

Date of Accident/Injury_____________________

_____________________________________________________________________________________

(Primary Insurance Company Name) (ID#) (Group#)

_____________________________________________________________________________________

(Address) (City/State/Zip) (Phone)

_____________________________________________________________________________________

(Policy Holders Name) (ID#) (INSURED Date of Birth)

WORKERS COMPENSATION (If applicable) Date of Injury_________________

_____________________________________________________________________________________

(Insurance Company Name) (Claim #) (Adjuster name and Phone)

Has an Incident Report been filed with your employer? ______________

## SECTION I: Anesthesia and Surgery History — If YES, List

1. Have you ever had surgery? If yes, please list. YES NO -

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________

2. Problems with anesthesia? YES NO If yes, please describe____________________

## SECTION II: Specific Medical History — If YES, List

1. Are you pregnant? YES NO Height ____________ Weight ________________

Have you had or do you still have:

| | | | |
|---|---|---|---|
| 2. Asthma? | YES | NO | ____________________ |
| 3. Emphysema? | YES | NO | ____________________ |
| 4. High Blood Pressure? | YES | NO | ____________________ |
| 5. Heart Trouble? | YES | NO | ____________________ |
| 6. Hepatitis or liver trouble? | YES | NO | ____________________ |
| 7. Kidney trouble? | YES | NO | ____________________ |
| 8. Diabetes? | YES | NO | ____________________ |
| 9. Epilepsy or seizures? | YES | NO | ____________________ |
| 10. Stroke? | YES | NO | ____________________ |
| 11. Problem Scarring? | YES | NO | ____________________ |
| 12. Have you been advised to or had psychiatric care? | YES | NO | ____________________ |

13. Others not listed? ________________________________________________

## SECTION III: Social History — If YES, List

| | | | |
|---|---|---|---|
| 1. Do you smoke? If yes, how much? | YES | NO | ____________________ |
| 2. Do you drink? If yes, how much? | YES | NO | ____________________ |
| 3. Do you have children? YES NO | How Many? | | ____________________ |

## SECTION IV: Family History — If YES, List

Have any blood relatives had any of the following?

| | | | |
|---|---|---|---|
| 1. Cancer | YES | NO | ____________________ |
| 2. Bleeding tendency | YES | NO | ____________________ |
| 3. Leukemia | YES | NO | ____________________ |
| 4. Heart Disease | YES | NO | ____________________ |
| 5. High Blood Pressure | YES | NO | ____________________ |
| 6. Repeated infections | YES | NO | ____________________ |
| 7. Chronic lung disease | YES | NO | ____________________ |
| 8. Tuberculosis | YES | NO | ____________________ |
| 9. Asthma | YES | NO | ____________________ |
| 10. Severe Allergies | YES | NO | ____________________ |
| 11. Kidney disease | YES | NO | ____________________ |
| 12. Crippling arthritis | YES | NO | ____________________ |
| 13. Mental Illness | YES | NO | ____________________ |
| 14. Convulsions or fits | YES | NO | ____________________ |

## CONTINUATION OF FAMILY HISTORY

15. Migraine headaches YES NO ____________________
16. Diabetes YES NO ____________________
17. Gout YES NO ____________________
18. Thyroid trouble YES NO ____________________
19. Obesity YES NO ____________________

Present age, or age at death | If living, health (good, fair, poor) | If deceased, cause of death

1. Father ________ ____________________ ____________________
2. Mother ________ ____________________ ____________________
3. Brothers/Sisters______ ____________________ ____________________

________________ ____________________ ____________________

## SECTION V: Medications — If YES, List

Are you allergic to any medications or local anesthetics? YES NO

______________________________________________________________

Are you taking or have you taken in the past:

1. Medication for blood pressure or water pills? YES NO____________
2. Antidepressants, tranquilizers or sedatives? YES NO____________
3. Blood thinners including Motrin, Advil or Aspirin? YES NO____________
4. Steroids? YES NO____________
5. Diabetic medications? YES NO____________
6. Seizures? YES NO____________
7. Heart medications? YES NO____________
8. Other medications? ______________________________________________

## SECTION VI: Review of Systems — If YES, List

| General | | | Cardiovascular System | | |
|---|---|---|---|---|---|
| 1. Tire easily, weakness | YES | NO | 1. Chest pain or discomfort | YES | NO |
| 2. Night sweats | YES | NO | 2. Difficulty breathing while lying down | YES | NO |
| 3. Persistent fever | YES | NO | 3. Bluish fingers or lips | YES | NO |
| 4. Sensitivity to cold or hot | YES | NO | 4. High blood pressure | YES | NO |
| 5. Irritability | YES | NO | 5. Vein trouble | YES | NO |
| 6. Sleeplessness | YES | NO | 6. Palpitations | YES | NO |
| 7. Marked recent weight loss | YES | NO | | | |
| | | | | | |
| Skin | | | Digestive System | | |
| 1. Eruptions (rash) | YES | NO | 1. Difficulty swallowing | YES | NO |
| 2. Change in color | YES | NO | 2. Heartburn | YES | NO |
| 3. Change in nails | YES | NO | 3. Abdominal distress | YES | NO |
| | | | 4. Belching or excess gas | YES | NO |
| Eyes | | | 5. Nausea | YES | NO |
| 1. Trouble seeing | YES | NO | 6. Vomiting | YES | NO |
| 2. Eye pain | YES | NO | 7. Rectal bleeding | YES | NO |
| 3. Inflamed eyes | YES | NO | 8. Tarry stools | YES | NO |
| 4. Double vision | YES | NO | 9. Jaundice | YES | NO |
| 5. Blurred vision | YES | NO | 10. Constipation | YES | NO |
| 6. Discharge | YES | NO | 11. Diarrhea | YES | NO |
| | | | 12. Hemorrhoids | YES | NO |
| | | | 13. Change in appetite | YES | NO |

| Ears | | | | | |
|---|---|---|---|---|---|
| 1. Loss of hearing | YES | NO | | | |
| 2. Ringing in ears | YES | NO | Genitourinary System | | |
| 3. Discharge | YES | NO | 1. Increase of frequency of urination | YES | NO |
| 4. Dizziness, vertigo | YES | NO | 2. Feel need but not much urine | YES | NO |
| | | | 3. Unable to hold urine | YES | NO |
| Nose | | | 4. Pain or burning | YES | NO |
| 1. Loss of smell | YES | NO | 5. Blood in urine | YES | NO |
| 2. Frequent colds | YES | NO | | | |
| 3. Obstruction | YES | NO | Endocrine | | |
| 4. Excess discharge | YES | NO | 1. Thyroid trouble | YES | NO |
| 5. Nosebleeds | YES | NO | 2. Adrenal trouble | YES | NO |
| | | | 3. Cortisone treatment | YES | NO |
| Mouth | | | 4. Diabetes | YES | NO |
| 1. Sore gums | YES | NO | | | |
| 2. Major dental problems | YES | NO | Musculoskeletal | | |
| 3. Bleeding gums | YES | NO | 1. Muscle cramps | YES | NO |
| | | | 2. Weakness of muscles | YES | NO |
| Throat | | | 3. Pain in joints | YES | NO |
| 1. Postnasal drainage | YES | NO | 4. Stiffness | YES | NO |
| 2. Soreness | YES | NO | 5. Deformity of joints | YES | NO |
| 3. Hoarseness | YES | NO | | | |
| 4. Voice Change | YES | NO | Nervous System | | |
| | | | 1. Headaches | YES | NO |
| Breasts | | | 2. Fainting | YES | NO |
| 1. Lumps | YES | NO | 3. Convulsions or fits | YES | NO |
| 2. Discharge | YES | NO | 4. Change in sensation | YES | NO |
| | | | 5. Memory loss | YES | NO |
| Respiratory System | | | 6. Poor coordination | YES | NO |
| 1. Cough, persisting | YES | NO | 7. Depression | YES | NO |
| 2. Sputum (phlegm) | YES | NO | 8. Nervousness | YES | NO |
| 3. Bloody sputum | YES | NO | | | |
| 4. Wheezing | YES | NO | | | |
| 5. Pain on breathing | YES | NO | | | |

I have read this questionnaire and answered the questions to the best of my knowledge.

______________________________ ______________________________

Patient Signature DATE

ADMIRE
PLASTIC SURGERY

# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the
patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate
for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I, ____________________________________________date_____________do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**