PATIENT INFORMATION

Personal Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Gender: Male Female Marital Status: M S W D

Address: _____
Street City State Zipcode

Home Phone: ( ) _____ Cell: ( ) _____ Work: ( ) _____

SSN#:_____ DL#: _____

Occupation: _____ Employer: _____

Spouse or Emergency Contact: _____ Phone#: _____

Email Address: _____

May we release information to your Spouse or Emergency Contact: (Please Check) ☐ Yes ☐ No

Referral Information:

Who or what referred you to Dr. Lee's office? Please specify below:

Patient: _____ Internet Website ☐

Physician: _____ Yahoo ☐ Google ☐ Other ☐

Other: _____ Magazine/ Newspaper: _____

Surgery/Financial

Desired surgery date or time frame? _____

Are you interested in financing? ☐ Yes ☐ No
(If yes, please ask our Patient Coordinator to approve you for a low monthly payment today!)

Is this your first time visiting a Plastic Surgeon? ☐ Yes ☐ No

If you are here for Botox or Juvederm, would like the procedure today? ☐ Yes ☐ No

MEDICAL INFORMATION

Name: _____ Date: _____

Height: _____ Weight: _____

Allergies to Medication: _____

Are you Allergic to Latex? ☐ Y ☐ N Are you Allergic to Adhesives? ☐ Y ☐ N

Known Food Allergies: _____

Current Medications

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you wear contacts? ☐ Y ☐ N Do you wear dentures? ☐ Y ☐ N

Date of Last Physical Exam: _____ By Whom? _____

Primary Care Physician: _____

Do you Use?				
	Alcohol	☐ Y	☐ N	How Often? _____
	Tobacco	☐ Y	☐ N	How Often? _____
	Aspirin	☐ Y	☐ N	How Often? _____
	Illicit/Street Drugs	☐ Y	☐ N	How Often? _____

Do you have bleeding problems? ☐ Y ☐ N Any difficulties with anesthesia? ☐ Y ☐ N

Any Medical Problems with: (please explain)

Epilepsy/Seizure	☐ Y	☐ N	_____
Headaches	☐ Y	☐ N	_____
Eyes	☐ Y	☐ N	_____
Diabetes	☐ Y	☐ N	_____
Ears	☐ Y	☐ N	_____
Nose	☐ Y	☐ N	_____
Ulcers	☐ Y	☐ N	_____
Thyroid	☐ Y	☐ N	_____
Lungs	☐ Y	☐ N	_____
Heart	☐ Y	☐ N	_____
Blood Pressure	☐ Y	☐ N	_____
Liver/Hepatitis	☐ Y	☐ N	_____
Kidneys/Bladder	☐ Y	☐ N	_____
Unsightly Scars	☐ Y	☐ N	_____
Other	☐ Y	☐ N	_____

MEDICAL INFORMATION CONTINUED

Please list any Previous Surgeries or Hospital Admissions Including Childbirth?

Type	Date	Complications

Any Current Medical Condition under Treatment by a Physician?

Family History of Medical Problems:

Mother: _____

Father: _____

Sister: _____

Brother: _____

Other:

PATIENT CONSENT FORM

I understand that, under the Health Insurance and Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____