Tri Valley PLASTIC SURGERY

Patient Form

Cosmetic

Personal Information

Name: ______________________ Today's Date: / /

Address: ______________________ Phone (H): ______________

City: ______________ State: ______ Zip : ________ Phone (C): ______________

Email: ______________________ Phone (W): ______________

Date of Birth: / / Age: ________

How did you hear about us? Internet: ☐Google ☐Facebook ☐Yelp ☐Other

Referral: ______________________

Other: ______________________

In case of emergency, who should be notified? ______________ Phone: ______________

Primary Care Physician: ______________________ Phone: ______________

Do we have your permission to:

Leave a message on your answering machine at home?	☐ Yes	☐ No
Leave a message at your place of employment?	☐ Yes	☐ No
Discuss your medical condition with any member of your household?	☐ Yes	☐ No
Send you information regarding promotions or specials we occasionally have?	☐ Yes	☐ No

(We will always protect your information.)

Notice to Consumers:

Medical doctors are licensed and regulated by the Medical Board of California, 800-633-2322, www.mbc.ca.gov.

Notice of Privacy Practices Acknowledgement:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 above to obtain a current copy of the Notice of Privacy Practices.

Patient Name: ______________________ Relationship to Patient: ______________

Signature: ______________________ Date: / /

Internal use ONLY
___ Scan ___ EMR ___ vTiger

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We wish to welcome you to Tri Valley Plastic Surgery. We are committed to providing excellent care. Please complete as much of the information below as possible.

What brings you to our office? Please be as specific as possible

____

____

What medical problems do you have?

____

____

What Surgery have you had previously?

____

____

What allergies to medications do you have? *(Including aspirin, birth control pills, vitamins, etc.)*

____

____

What medications do you take?

____

____

Do you currently smoke? ☐ Yes ☐ No If yes, how many packs per day? ______ How many years? ______

Have you ever smoked? ☐ Yes ☐ No If yes, how many packs per day? ______ How many years? ______

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? ______ How often? ______

Do you have any relatives who have had breast cancer? ☐ Yes ☐ No If yes, who? ______

Do you have a problem with excessive scarring or keloid formation after being cut? ☐ Yes ☐ No

Is your general health good? ☐ Yes ☐ No

Have you ever had psychiatric problems, or been under the care of a psychiatrist, psychologist or mental health counselor? ☐ Yes ☐ No

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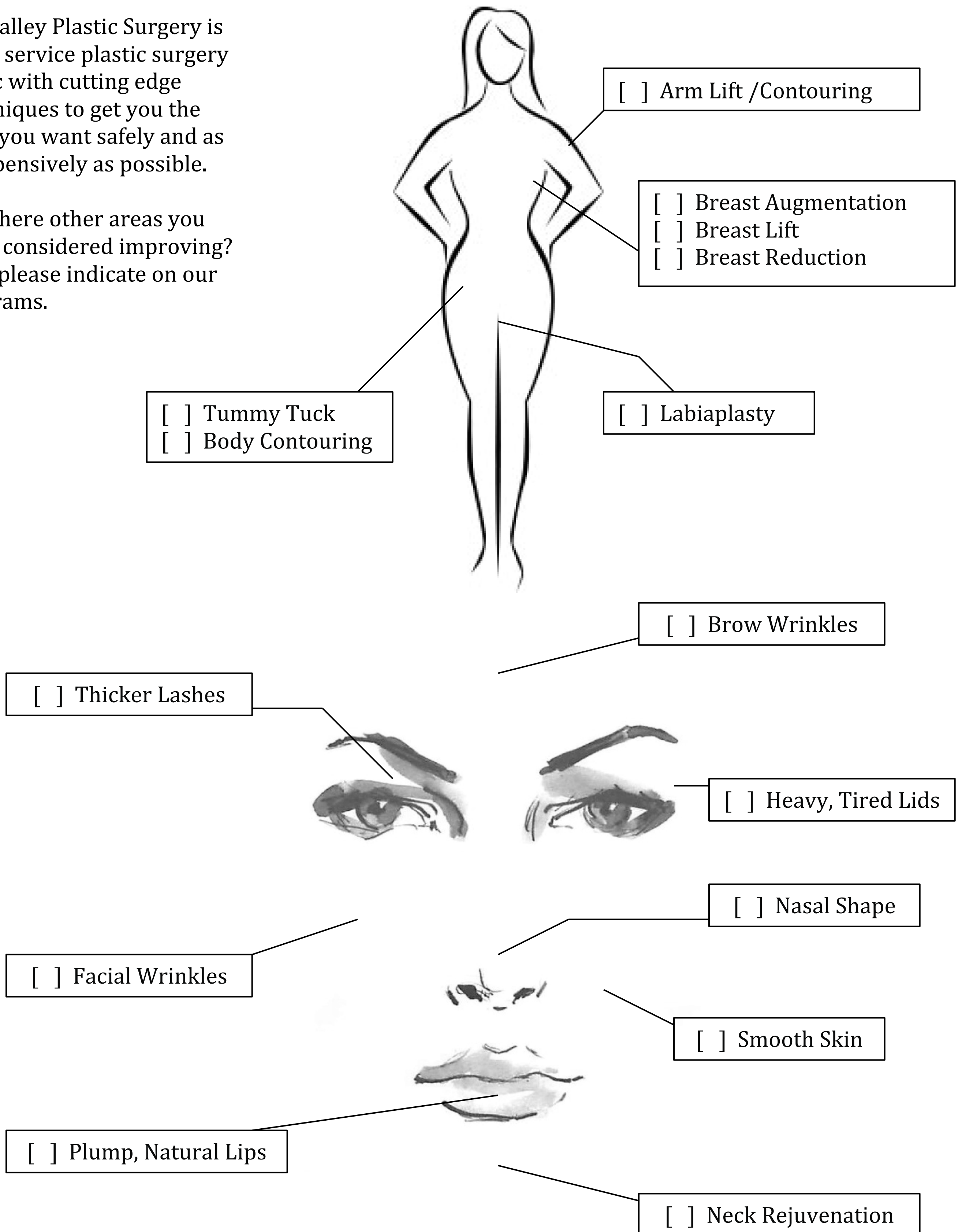
Tri Valley Plastic Surgery is a full service plastic surgery clinic with cutting edge techniques to get you the look you want safely and as inexpensively as possible.

Are there other areas you have considered improving? If so please indicate on our diagrams.



Tri Valley
PLASTIC SURGERY

Consent for Medical Photography

The Undersigned hereby consents to have photographs taken in the course of:

1. Pre-operative evaluation and planning
2. Intra-operative or procedural documentation or evaluation
3. Post-operative documentation or evaluation

The term "photograph" as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

The undersigned acknowledges understanding that photographs may be used in the course of treatment, research, educational and informational programs as my physician deems appropriate and that such use is subject only to the following limitations:

____

____

____

Date: / / Time: ______________________________

Signature: ____

If by someone other than patient indicate relationship: ______________________________

Witness: ____