Tri Valley Plastic Surgery

Patient Form

Insurance

Personal Information

Name: _____ Today's Date: / /

Address: _____ Phone (H): _____

City: _____ State: _____ Zip : _____ Phone (C): _____

Email: _____ Phone (W): _____

Date of Birth: / / Age: _____ Sex: ☐M ☐F Height: _____ Weight: _____

Employer? _____

Who referred you to our office? _____

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

Primary Care Physician: _____ Phone: _____

Pharmacy Information: _____ Location: _____ Phone: _____

Insurance information

Do you require a REFERRAL for this visit? : _____

Primary Insurance Name: _____ ***Secondary*** Insurance Name: _____

Ins. Address: _____ Ins. Address: _____

Name of Insured: _____ Name of Insured: _____

Insured's ID#: _____ Insured's ID#: _____

Insured's Date of Birth: / / Insured's Date of Birth: / /

Group#: _____ Group#: _____

Relationship of patient to the Insured: _____ Relationship of patient to the Insured: _____

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

If yes, whom: _____ Relationship: _____

_____ ____/____/_____

Signature of patient or legal guardian Date

Internal use ONLY
___ Scan ___ EMR ___ vTiger

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

How long have you had this condition? _____

Have you had any previous treatment for this condition? _____

If YES, how and when was this treated? _____

Review of systems

Do you have or have you had any of the following? (Please check yes or no.)

AIDS or HIV positive	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Irregular heart beat	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No
Back problems	☐ Yes	☐ No	Migraine headaches	☐ Yes	☐ No
Blood clots in legs	☐ Yes	☐ No	Nervous breakdown	☐ Yes	☐ No
Blood disorders	☐ Yes	☐ No	Nose/throat problems	☐ Yes	☐ No
Bleeding problems	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Breathing problems	☐ Yes	☐ No	Psychiatric condition	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Chest pains	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Skin cancer	☐ Yes	☐ No
Ear/Eye problems	☐ Yes	☐ No	Stomach problems	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart palpitations	☐ Yes	☐ No	Transfusion	☐ Yes	☐ No

Past, family and/or social history

Current medical conditions: _____

List any hospitalizations and/or previous surgery (including cosmetic/plastic surgery), with dates:

_____

Are you allergic to or have you ever had a reaction to any medication or drug; local anesthetic; or general anesthetic? _____

Are you now or have you ever taken any medications regularly (aspirin, birth control pills, vitamins, etc.)?

Currently taking: _____

Previously taken: _____

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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? _____

Have you ever had a mammogram? ☐ Yes ☐ No If yes, when was your last one? _____

Have you had exposure to any of the following? Radiation ☐ Yes ☐ No Excessive sun ☐ Yes ☐ No

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

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

Is your general health good? ☐ Yes ☐ No

Contact authorization

According to federal law we must ask for your permission to send to you via email or regular mail information regarding our practice such as products we sell, promotions we have or any services the practice offers (i.e., office promotions that include Botox events and/or special discounts). Our office **DOES NOT** sell or shares our patient's information.

I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying TVPS in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by TVPS in reliance on this authorization before TVPS receives my request for revocation or modification. I must sign my written request and send it to:

Tri Valley Plastic Surgery
4000 Dublin Blvd. Suite 300
Dublin, CA 94568

I DO _____ I DO NOT _____

Authorize Tri Valley Plastic Surgery ("TVPS") to use and disclose my Protected Health Information ("PHI") to mail to me any information regarding the products, services, or promotions the practice offers.

_____ ____/____/____

Patient Signature Date

_____

Email Address (Please Print)

If not signed by the patient, please indicate relationship: _____

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: / /

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Consent for medical photography

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

- Pre-operative evaluation and planning
- Intra-operative or procedural documentation or evaluation
- 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:

_____

_____

Signature: _____ Date: / / Time: _____

If by someone other than patient indicate relationship: _____

Witness: _____