SUGAR LAND

PLASTIC & RECONSTRUCTIVE SURGERY, COSMETIC SURGERY

PATIENT INFORMATION FORM

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Gender: _____

Social Security Number: _____ Marital Status: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about our clinic?

☐ Focus Magazine ☐ Patient Referral: _____ ☐ Health & Fitness Magazine
☐ Vietnamese Magazine ☐ Friend: _____ ☐ LoveYourLook.com
☐ Web Search Engine ☐ Dr. Referral: _____ ☐ Houston Press
☐ Other: _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Release Results

If it's ok to leave a message with another person, please list them:

Name	Relationship	Comments

Assignment and Release

I, _____ (print name), have insurance coverage and assign directly to Dr. Nguyen all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured / Guardian Date

Procedures of Interest

Body:

- ☐ Liposuction
- ☐ Tummy tuck
- ☐ Buttock lift
- ☐ Thigh lift
- ☐ Buttock enlargement (Brazilian Butt Lift)
- ☐ Correction of tummy tuck or liposuction
- ☐ Arm lift
- ☐ Body lift
- ☐ Hernia repair
- ☐ Labia repair
- ☐ Other:

Breast:

- ☐ Breast enlargement
- ☐ Breast implant revision
- ☐ Breast reduction
- ☐ Breast lift
- ☐ Breast lift with enlargement
- ☐ Nipple reduction
- ☐ Correction of inverted nipples
- ☐ Male chest reduction

Face:

- ☐ Nose surgery
- ☐ Breathing problems
- ☐ Eyelid lift
- ☐ Brow lift
- ☐ Face lift
- ☐ Ear pinning
- ☐ Neck lift or liposuction
- ☐ Chin enlargement
- ☐ Buccal fat removal

In Office:

- ☐ Botox
- ☐ Juvederm
- ☐ Latisse
- ☐ Skin care
- ☐ Scar revision
- ☐ Mole removal
- ☐ Radiesse
- ☐ Lip augmentation

Skin Transformation

☐ **GloMinerals –** a mineral make-up formulated using powerful pharmaceutical-grade antioxidants, natural, high pigment minerals and broad spectrum UV protection. These products are designed to deliver a flawless complexion while improving the health and appearance of the skin and protecting it from the outside - in.

☐ **Dermesse**- (Sun Damage, Wrinkles, Tightening)- This Skin Health System helps build a strong, healthier skin barrier from the inside-out. By enhancing the skin barrier's function, overall skin tone and texture improve and the appearance of sun damage, hyperpigmentation and brown spots are reduced, if not eliminated.

☐ **Latisse® -** Available by Rx only. A solution applied once daily to your upper lash-line. This makes lashes, longer, thicker and darker.

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

   Surgery Type: _____ Year: _____

   Surgery Type: _____ Year: _____

   Surgery Type: _____ Year: _____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

   _____

   _____

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

Have you or do you still have:	No	Yes	Description
2. Asthma	☐	☐	
3. Emphysema	☐	☐	
4. High Blood Pressure	☐	☐	
5. Heart Trouble	☐	☐	
6. Hepatitis or Liver Trouble	☐	☐	
7. Kidney Trouble	☐	☐	
8. Diabetes	☐	☐	
9. Epilepsy or Seizures	☐	☐	
10. Stroke	☐	☐	
11. Problem Scarring	☐	☐	
12. Have you been advised to or had psychiatric care?	☐	☐	

13. Others Not Listed: _____

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____
3. Do you have children? ☐ No ☐ Yes, how many? _____

Section IV: Medications

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

_____

Section V: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

_____

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

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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, _____ (print name), do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____