Welcome to VICTORIA PLASTIC SURGERY CENTER

Today's Date: _____ SSN#: _____ Driver's License #: _____

Name: _____ DOB: _____ / _____ / _____ AGE: _____
Last First

Home Address: _____
Street Apt. #

_____
City State Zip Code

Home Phone:(_____) _____Pager/Cell: (_____)_____Work Phone: (_____) _____

Best Time & Number to reach you? _____ **Email**: _____

Employer: _____ How Long There? _____ Occupation: _____

Employer's Address: _____

Whom May We Thank for the Referral? _____

Other Family Members Seen By Us? _____

EMERGENCY CONTACT

His/Her Name: _____ Relation: _____

Home Phone:(_____) _____Pager/Cell: (_____)_____Work Phone: (_____) _____

SPOUSE OR PARENT/GUARDIAN INFORMATION

His/Her Name: _____ Relation: _____

DOB: _____ / _____ / _____ SSN#: _____ Driver's License #: _____

Home Phone:(____) _____Pager/Cell: (____)_____Work Phone: (____) _____

Employer: _____ How Long There? _____ Occupation: _____

Employer's Address: _____

PERMISSION TO PHOTOGRAPH

☐ I HEREBY AUTHORIZE DR. SUH or any staffs that she may engage for this purpose, to take such photographs/video tape of me as she desires before, during, and after surgery, which is to be performed on me. Photographs/videos is required to receive services and will be kept confidential for record keeping purposes. Furthermore, I would not be identified by name thus I authorize ☐ , I do not authorize ☐ such photographs to be published in professional journals and medical books, to be used for educational/research purposes, or for advertising, or in the event of legal action not of myself. This release is a general lifetime release, and I agree that no compensation will be given or sought for such use of my images.

Patient's Signature: _____ Date: _____ / _____ / _____ Relationship to Patient: _____

Name of Personal Physician: _____ Phone: (_____) _____

Office Address: _____

Date of Late Visit: _____ / _____ / _____ Your Current Health is: Good ____ Fair ____ Poor ____

Are you currently under the care of a Physician? Yes No If Yes, Please Explain: _____

Purpose of Visit/Procedure: _____

Have you seen other Plastic Surgeons for the same problem that brings you here? Yes No May We Contact Him/Her? Yes No

Name of Physician: _____ Phone: (_____) _____

Is the problem related to personal injury? Yes No Is the problem work related injury? Yes No Date of Injury: _____

Besides the Above Reason for consultation, would you like Dr. Suh to discuss other cosmetic procedures to enhance your appearance? Yes No

Do you have any personal problems that preoccupies you? Yes No If Yes, Please Explain: _____

For Women:

Are you Pregnant? No Unsure Yes # of Weeks ____ Please Note-You CANNOT have surgery if you are PREGNANT!!

Age of Menarche (menstruation): _____ Age of First Pregnancy: _____ Number of Pregnancies: _____ Number of Children: _____

Breast Feed: Yes No Breast Lumps: Yes No Last Mammogram Date: _____ / _____ / _____

Health History

Family Medical Problem: Please Identify any Medical Problems Blood Relatives Have or Ever Had

Condition	Family Member	Condition	Family Member	Condition	Family Member
Birth Defect		Cancer		Rheumatic	
Melanoma		Collagen Vascular Dz.		Fever	
Mental Retardation		Diabetes		Kidney Disease	
Allergies		Eye Disease		Mental Disease	
Lung Disease		Ear Disease		Seizures	
Asthma		Heart Disease		Thyroid Disease	
Bone/Joint Disorder		Anemia/Blood Disease		Tuberculosis (TB)	
Rheumatoid Arthritis		High Blood Pressure		Other _____	

Please Tell Us your Health History

Height _____Ft. _____in. Weight? _____lbs. Bra Size: _____ Male Female Marital Status_____

Do you Smoke/Tobacco/Use Nicotine? No Yes Daily Amount? _____

Do you Drink Alcoholic Beverages? No Yes Daily Amount? _____

Do you Use Drug? No Yes Name of Drug(S): _____

List ALL SURGERIES you have ever had in the past: _____

_____

_____

Past Medical History: Do you presently have or have you experienced the following? Please Circle all that apply!

AIDS	Depression	Hay Fever	Lupus	Scarlet Fever	Tonsillitis
Alcohol Abuse	Diabetes	Heart Disease	Mental Illness	Seizures	Tuberculosis
Anemia	Drug Abuse	Hemophilia	Mitral Valve Prolapse	Shingles	Venereal Disease
Arthritis	DVT	Hepatitis	Pacemaker	Sinus Disease	
Asthma	Emphysema	High Blood Pressure	PE Pulmonary Embolus	Sickle Cell	
Cancer	Epilepsy	Kidney Problem	Radiation TX	Stroke	
Chicken Pox	Fever Blisters	Liver Problems	Reproductive DZ	Stomach Ulcers	
Colitis	Glaucoma	Low Blood Pressure	Rheumatic DZ	Thyroid Problem	

Please list any Other Serious Medical Conditions that you have Experienced: _____

_____

ROS: Do you have these conditions? Please Check all that apply:

___Chronic Cough	___Rapid Heart Beat	___Chest Pain
___Weight Change	___Seizures	___Dry Eyes
___Keloids	___Easy Bleeding	___Jaundice
___Swollen Feet/Ankle	___Chronic Diarrhea	___Skin Rash
___Joint/Muscle Pain	___Swollen Lymph Node	

Are you Allergic to any of the following? Please Check all that apply:

___Aspirin	___Iodine	___Sedatives
___Barbiturates	___Jewelry	___Sulfa Drugs
___Codeine	___Penicillin	___Tetracycline
___Erythromycin	___Latex	___Narcotics
___Anesthesia	___Tape	

Other: _____

Medications: Please Include Everything- Prescriptions, Vitamins, Herbals, Etc... Name Dosage Frequency
It Is mandatory that certain Drugs, Vitamins, Herbals that cause blood thinning be stopped many days prior to any Surgery!

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please Note: It is Mandatory to (QUIT SMOKING) 3 Weeks before and 3-6 Weeks after surgery. If you cannot comply, please let us know! _____ Yes, I can Stop Smoking _____ No, I cannot Stop Smoking

Signature: _____ Date: _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

HIPAA Compliance Patient Consent Form

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

**Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
**Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
**Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we already have taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Offer.

**The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any person identifiable by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

**The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alterative locations.
**The right to inspect and copy your protected health information.
**The right to amend your protected health information.
**The right to receive an accounting of disclosures of protected health information.
**The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 1, 2003 and we are required to abide by the terms of this Notice of Privacy Practice currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from this office.

HIPAA (Continued)

Our notice of privacy practices (on the back) provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operation
- The practice reserves the right to change the privacy policy as allowed by law
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

YES / NO May we phone you to confirm appointments?

YES / NO May we leave a message on your answering machine at home or on your cell?

YES / NO May we email to your specified email address personal private health information including but not limited to laboratory reports, treatment recommendations, relevant scientific articles and medical forms?

YES / NO May we discuss your medical condition with any member of your family?

If YES, please name the members allowed:

☐ Spouse/Partner ☐ Child(ren) ☐ Other (Relationship): _____

Full Name: _____

Phone or Address: _____

Patient's Print Name: _____

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____