Signature Plastic Surgery & Aesthetics

ELEONORE ZETRENNE M.D., MARK KOBAYASHI M.D., DJ JOHN PARK M.D.

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Patient First Name:	Last Name:	Middle	
Street Address:		City:	State	Zip:
Martial Status:	Home Phone:	Work Phone:	Cell Phone:	
Social Security Number:	Birth Date:	Gender: ☐ M ☐ F	How did you hear about us:	
Occupation:	Employer:		Employer Phone Number:	
If patient is a minor, who may authorize treatment:			Relationship:	
EMAIL ADDRESS:				

RESPONSIBLE PARTY / INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person Financially Responsible For Treatment, if not self:	Birth Date:	Social Security Number:	
Address (if different):	Phone Number:		
Occupation:	Employer:	Employer Address:	Employer Phone Number:
Is this patient covered by insurance? ☐ Yes ☐ No			
Subscriber's Name	Address:		
Name of Primary Insurance Company:	Group Number:	Policy Number:	Co-payment:
Patient's relationship to subscriber:	☐ Self ☐ Spouse ☐ Child ☐ Other		
Name of Secondary Insurance Company (if applicable):	Subscriber's Name:	Group Number:	Policy Number:
Patient's relationship to subscriber:	☐ Self ☐ Spouse ☐ Child ☐ Other		
If Workers Compensation, Treatment Authorized By:	Claim Number:		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone:	Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my physician or insurance company to release any information required to process my claims.

Patient/Guardian Signature: **Date:**

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PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Primary Care Office Phone # _____

Reason for Consultation: _____

PLEASE LIST ANY DRUG AND/OR LATEX ALLERGIES

MEDICATIONS: List medication name including over-the-counter, herbal remedies, inhalers, eye drops, etc.	
1.	5.
2.	6.
3.	7.
4.	8.

PREVIOUS SURGERIES:	YEAR	COMPLICATIONS	TYPE OF ANESTHESIA

Please check the appropriate box in each section below:

GENERAL HEALTHCARE	YES	NO
Cancer	☐	☐
Location:_____		
Radiation Therapy	☐	☐
Chemotherapy	☐	☐
Immune Deficiency	☐	☐

SURGICAL INFORMATION	YES	NO
Do you have specific needs?	☐	☐
Hearing	☐	☐
Vision	☐	☐
Living Alone	☐	☐
Transportation	☐	☐
Do you exercise?	☐	☐
Type:_____	☐	☐
Scarring Problems?	☐	☐
Explain:_____		

SOCIAL HISTORY		YES	NO
Do you drink Alcohol?	Amount:_____	☐	☐
Do you smoke?		☐	☐
Did you ever smoke?	Years:_____	☐	☐
Have you smoked within the past 6 months?		☐	☐
Do you use recreational drugs? Type:_____		☐	☐

	YES	NO
Do you wear contact lenses?	☐	☐
Do you have caps, bridges, dentures, or loose teeth?	☐	☐
Personal or family history of anesthesia problems?	☐	☐
History of MRSA or Staph Infections?	☐	☐

FEMALE PATIENTS	YES	NO
Possibility of pregnancy?	☐	☐
Do you have children?	☐	☐
Delivery Method:_____		
Last menstrual period:_____		

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PATIENT HISTORY QUESTIONNAIRE CONTINUED

Patient Name:_____

Please Check if you have had any of the following CARDIAC/MEDICAL procedures:

☐ Angioplasty/Stent Placement	Year placed:	
☐ Echocardiogram		
☐ Stress Test		
☐ Pacemaker/Defibrillator	Model/Brand#	
CARDIOLOGIST:	Last Seen:	Cardiologist Office #

Please check if you have been told you have had any of the following health issues:

CARDIOVASCULAR

- ☐ Hypertension
- ☐ Heart Attack – Date:_____
- ☐ Coronary Artery Disease
- ☐ Cardiomyopathy
- ☐ Congestive Heart Failure
- ☐ Arrhythmia, i.e., A-Fib
- ☐ Heart Valve Problems
- ☐ Heart Murmur
- ☐ Carotid Artery Disease
- ☐ Chest Pain/Angina
- ☐ High Cholesterol
- ☐ Poor circulation in lower extremities
- ☐ Family history of Heart Disease

GASTROINTESTINAL

- ☐ Hiatal Hernia
- ☐ Ulcers/Gastric Reflux (circle)
- ☐ Gallstones
- ☐ Liver Disease
- ☐ Hepatitis A, B, or C

GENITOURINARY

- ☐ Urinary Tract Infections
- ☐ Kidney Stones
- ☐ Dialysis
- ☐ Prostate Disease

PAIN

- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Chronic Pain treatment
- ☐ Back/Neck Pain
- ☐ Artificial Joint

  Location:

HEMATOLOGIC

- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Blood Transfusions
- ☐ Easy Bruising

PULMONARY

- ☐ Asthma
- ☐ Bronchitis/Emphysema (circle)
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Blood clots in lungs or legs
- ☐ Sleep Apnea

ENDOCRINE

- ☐ Diabetes

  Type:_____
- ☐ Hypo/Hyperthyroidism
- ☐ Hypoglycemia

NEUROLOGIC

- ☐ Stroke
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Paralysis
- ☐ Muscle Weakness
- ☐ Headache
- ☐ Fainting
- ☐ Numbness

The above information is accurate and complete to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Print Name: _____

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INSURANCE COVERAGE STATEMENT

To Our Valued Patients:

This is to acknowledge that some of our physicians are non-contracted with any insurance carriers with the exception of Medicare. Dr. Park is a contracted provider under most PPO's, but not all.

For those Emergency Room patients, we cannot be responsible for what the hospital tells you, since they do not know which doctors are contacted with which insurance carriers, if any at all. We are there to perform a service on either an urgent or emergent basis, or at the request of the patient directly. You are responsible for charges incurred for services rendered at the time you are seen. Our office will collect fees for those services at your first post operative visit, i.e. deductibles, copays, or balance in full for our non-contracted providers . We will not carry unpaid balances. All patient liabilities are due in full .

We apologize for any hardship this may cause. Our office will help direct you with regards to your insurance carriers.

X _____ _____

Signature of patient / or guardian if patient is a minor Date

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HIPAA PRIVACY

AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated there under, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Signature Plastic Surgery & Aesthetics will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose medical and billing for the purpose of care and treatment.

By signing this authorization you agree that Covered Entity or its Business Associates may disclose your personal health care information to healthcare services.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to 4716 Barranca Parkway Irvine, CA 92604.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for disclosure by the recipient and no longer protected under HIPAA.

Covered Entity will provide (Name of patient):_____ with a copy of this signed authorization.

Acknowledged and agreed to by:

Patient Signature:_____ _____
Date

Print Name:_____

or, ON BEHALF OF PATIENT

By:_____ _____
Date

Print Name_____

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NOTICE OF RECORDS RELEASE

I authorize the release of my patient health information to the following personal contacts (Spouse, Child, Assistant, etc.). I understand that it is my responsibility to notify Signature Plastic Surgery and Aesthetics of any changes in the following information below.

Name	Relationship	
		☐ Appointment Information ☐ Treatment Information ☐ Billing Information
		☐ Appointment Information ☐ Treatment Information ☐ Billing Information
		☐ Appointment Information ☐ Treatment Information ☐ Billing Information
		☐ Appointment Information ☐ Treatment Information ☐ Billing Information

Signature of Patient/Responsible Party	Printed Name	Date

Consent for Taking and Publication of Photos

In connection with the medical services which I am receiving from my physician, Dr._____ , I consent that photographs may be taken of me or parts of my body under the following conditions:

- These photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him/her.
- The photographs shall be taken by my physician or by a photographer approved by my physician.
- The photographs shall be used for medical records and if in the judgment of my physician, medical research, education, or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, in print or electronic format including Dr. Kobayashi website, or used for any other purpose which he may deem proper in the interest of medical and patient education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.
- I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.
- I understand I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Kobayashi.
- I understand that the information disclosed, or some portion thereof, may be protected by the state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

"I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc."

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Decline: _____ Date: