DESERTAESTHETIC
&
VeinCentre

Patient Information

Thank you for choosing our office! In order to serve you properly, we need all of the following information. Please print. All information will be confidential.

Reason for your visit: ____________________________ How did you hear about us?____

Patient Name

____

(Name) (Middle Initial) (Last Name)

Addresss

____

(Street and Apartment) (City) (State) (Zip Code)

SS#__________
Date of birth __________
Age __________

Gender
□Male
□Female

Civil Status
□Single
□Married to:__________
□Other__________

Occupation
____
Employer
____

Contact Information:

Home phone: _______________
Work phone: _______________
Cell phone: _______________
Email address:
____

Can we leave a message for you at home?	□Yes □ No
Can we leave a message for you at work?	□Yes □ No
Can we send you a text message?	□Yes □ No
Can we send you an email to this email address?	□Yes □ No

Preferred method of contact: □Home □Work □Cell

In case of an emergency:

Call ________________________________

Relationship to patient:
____

Home phone: ____

Work/ Cell Phone Number:
____

Complete this section only if someone who is not the patient is financially responsible

Person responsible ____________________	Relation to patient ____________________	
Address ____________________	Work/ Cell Phone Number ____________________	
Preferred Number: ____________________	Date of Birth ____________________	SS# ____________________

REVIEW OF SYSTEMS Please mark if you have any of the following:

Breast:
- ☐ Breast pain
- ☐ Lumps
- ☐ Nipple discharge
- ☐ Dimpling
- ☐ Previous biopsy
- ☐ Specialty bras
- ☐ Breast implants
- ☐ Change in size

Neurological:
- ☐ Headaches
- ☐ Migraines
- ☐ Previous concussion
- ☐ Convulsions
- ☐ Numbness
- ☐ Gait difficultness
- ☐ Memory problems
- ☐ Tremors
- ☐ Stroke
- ☐ Epilepsy/ Seizure disorder

Skin:
- ☐ Color changes
- ☐ Previous skin cancer
- ☐ Birthmark
- ☐ Excessive Sweating
- ☐ Hair loss
- ☐ Stretch marks

General Symptoms:
- ☐ Fatigue
- ☐ Sleep difficultness
- ☐ Unexplained Fevers
- ☐ Loss of appetite
- ☐Unexplained weight loss
- ☐ Recent weight gain
- ☐ Fainting spells
- ☐ Sleep Apnea

Lung:
- ☐ Chronic cough
- ☐ Pain with deep breathing
- ☐ Bloody septum
- ☐ Recent infection
- ☐ Asthma
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Cystic Fibrosis

Musculoskeletal
- ☐ Neck mobility problems
- ☐ Joint pains
- ☐ Weakness
- ☐ Chronic back pain
- ☐ Shoulder grooving/pain
- ☐ Scoliosis
- ☐ Torticollis
- ☐ Muscular dystrophy

Hematology/ Oncology:
- ☐ Abnormal bleeding
- ☐ Blood clots
- ☐ Anemia
- ☐ High blood pressure
- ☐ Sickle-Cell disease
- ☐ Hepatitis
- ☐ Chemotherapy
- ☐ Easy bruising
- ☐ Radiation therapy
- ☐ History of cancer

Type of Cancer:

____

Heart:
- ☐ Chest pain
- ☐ Palpitations
- ☐ Heart defect
- ☐ Abnormal stress test
- ☐ Arrhythmias
- ☐ Heart attack
- ☐ Coronary Stents
- ☐ Heart murmur
- ☐ Lightheadedness/ Syncope

FAMILY HISTORY Have any blood relatives ever had any of the following? (Mark all that apply)
- ☐Adopted of family history unknown
- ☐ Breast cancer
- ☐ Tuberculosis
- ☐ Birth defects
- ☐ Heart disease
- ☐ Cleft lip or palate
- ☐ AIDS/HIV
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Cystic fibrosis
- ☐ Mental illness/bipolar
- ☐ Blood clots
- ☐ High blood pressure
- ☐ Sickle cell disease/trait
- ☐ Mental delay/ retardation
- ☐ Stroke
- ☐ Anesthesia problems

List any other serious illness not listed here:

____

____

DO YOU USE ANY OF THE FOLLOWING?

□ Insulin □ Coumadin □ Oxygen □ Steroids □ Aspirin or Ibuprofen

PERSONAL PAST MEDICAL HISTORY

Have you been hospitalized in the past 6 months? □ No □ Yes: ____

Are your immunizations current? □ No □ Yes □ Unsure

DO YOU WEAR ANY OF THE FOLLOWING?

□ Contact Lenses □ Eye glasses □ Hearing aid(s)

□ Dentures □ Orthodontics/braces □ Limb prosthesis or brace: __________

PAST SURGERIES □ NO PREVIOUS SURGERIES

DATE: TYPE: HOSPITAL: SURGEON:

____

____

____

Have you ever had a transfusion? □ No □ Yes? If yes, when: __________

HAVE YOU HAD ANY COMPLICATIONS OR BAD REACTIONS TO ANESTHESIA?

□ Never received general anesthesia □ Difficult intubation □ Difficult extubation

□ Malignant hyperthermia □ Post op nausea/vomiting □ Allergic reaction

□ Difficulty waking up □ Sensitivity to anesthesia agent □ No past anesthesia problems

WOMEN ONLY

Are you currently pregnant? □ No □ Yes □ Maybe

Number of pregnancies: __________ Number of natural births: __________

Did you breastfeed? □ No □ Yes

Number of adopted children: __________ Last menstrual cycle: __________

Date of last mammogram: Have you had your tubes tied? □ No □ Yes

Have you had a hysterectomy? □ No □ Yes

SOCIAL HISTORY

Occupation:__________ Name of significant other:__________ Hobbies:__________

Is a responsible adult available to assist during surgery recovery period? □ No □ Yes

Do you smoke? □ No □ Yes Cigarettes Cigars Pipes Marijuana How much?__________

Have you ever smoked? □ No □ Yes Number of years smoked___________ Date quit: ___________

Are you aware that smoking increases the surgical complication? □ No □ Yes

Do you drink alcohol? □ No □ Yes How much? __________

Do you have a history of drinking to excess □ No □ Yes Date quit: __________

DESERTAESTHETIC
&
VeinCentre

Do you use any recreational drugs? □ No □ Yes List:____

PLEASE LIST ANY MEDICATION ALLERGIES

MEDICATION: ________________________ REACTION: ________________________
MEDICATION: ________________________ REACTION: ________________________
MEDICATION: ________________________ REACTION: ________________________
MEDICATION: ________________________ REACTION: ________________________
MEDICATION: ________________________ REACTION: ________________________
MEDICATION: ________________________ REACTION: ________________________

MEDICATION LIST

MEDICATION NAME	DOSAGE	FREQUENCY	INDICATION

Authorization and Release of Patient Photography

□I consent to the taking of photographs or videos of me or parts of my body by Dr. Ted Y Fisher or his designee. in connection with my medical care or plastic surgery procedure(s) to be performed by Dr. Y Fisher. Preoperative and postoperative photographs of me will be used solely for the purposes of confidential clinical records and will remain the property of Dr. Ted Y. Fisher.

□I further consent to the publication by Dr. Ted Y. Fisher or his designated representatives of such photographs, videotapes, or case histories to appropriate insurance companies for surgical pre-authorization and / or review of claims.
I fully and specifically grant my permission to use photographs, videos or case information for the following additional purposes, as indicated by my initials below. As a result of this use I understand that these photographs, videotapes, or the case information may appear in related, updated, or reprinted formats at any concurrent or future occasion. Neither I, nor any member of my family, will be identified by name in any publication. I understand that such consent is strictly on a volunteer basis. I understand that I may refuse to sign this additional authorization and that such refusal will have no effect on the medical treatment I receive from Dr. Ted Y. Fisher. I understand that a copy of this consent may be provided with images to any third party where they may be published, or presented. I understand that some photographs may, by their representation, make me identifiable in appearance to others. I authorize Dr. Ted Y. Fisher to use my photographs, videos, and case information to the following educational or scientific settings:

- ❖ Medical journals and textbooks, scientific presentations and teaching courses in any prior, visual or electronic media, for the purpose of informing the medical profession about plastic surgery methods.
- ❖ My surgeon's office patient education materials, including pre- and postoperative photographs available only for prospective patients to for viewing in the office.
- ❖ My surgeon's personal web site or web page
- ❖ Lectures and multimedia presentations given by my surgeon to the general public
- ❖ Television programs in which my surgeon participates
- ❖ Newspapers or magazines articles from in which my surgeon participates
- ❖ Case studies presented on professional websites and society
- ❖ Photographs can be used for testing purposes by the American Board of Plastic Surgery

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any action taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below
I understand that the information disclosed, or some portion thereof may be protected by state law and /or the federal Health Portability and Accountability Act of 1996. ("HIPAA")

I release and discharge Dr. Ted Y. Fisher and all parties acting under their license and authority from all rights that I may have in the photographs, videotapes or cast histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary action and certify that I have read the above authorization and release and fully understand its terms.

Patient Name ______________________________ Date ____________________________
Patient Signature ______________________________ Date ____________________________
(Parent/Guardian Signature if patient under the age of 18 years old)
Witness ______________________________ Date ____________________________

<u>Notice of Privacy Policy</u>

Patient's Name: ____

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before you sign this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may request a revised copy of the Privacy Officer.

Please indicate persons (other than insurers and health professionals) who are authorized to receive protected health information about you

□No One

Name:_______________________________________Relation___________________________________
Name:_______________________________________Relation___________________________________
Name:_______________________________________Relation___________________________________

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all purposes set in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, which understands the content of our Notice and how it applies to you, and that all of your questions regarding the content of our Notice have been answered.

By signing this form, you acknowledge your right to revoke your consent in writing, except to the extent that the practices has already made disclosures based on your prior consent.

Patient Name ___________________________ Date ___________________________
Patient Signature ___________________________ Date ___________________________
(Parent/Guardian Signature if patient under the age of 18 years old)

<u>Payment Policy</u>

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Ted Y. Fisher to bill my insurance company. I agree to pay all deductible, copay, and non-covered service amounts. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Ted Y. Fisher and myself.
Patient Name ___________________________ Date ___________________________
Patient Signature ___________________________ Date ___________________________
(Parent/Guardian Signature if patient under the age of 18 years old)