Face N Body
1330 San Bernardino Road, Suite C
Upland, CA 91786
(909) 981-8985
www.FaceNBody.com

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AESTHETICS & PLASTIC SURGERY

# Patient Information Form

Patient Name: ______________________ Today's Date: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

Home Phone: ______________ Cell Phone: ______________ Carrier: ______________

Best Time to Call: ______________ ▶ OK to send text messages: ☐ Yes ☐ No

DOB & Age: ______________ Sex: ______________ Marital Status: ______________

Email Address: ______________ OK to send emails: ☐ Yes ☐ No *For up to date news & special offers*

Employer Name: ______________ Address: ______________

Occupation: ______________ Work Phone: ______________

Who is your primary care physician? ______________

How did you hear about our office: Are you interested in our Care Credit Financing? Yes No

- ☐ FaceNBody.com
- ☐ Facebook
- ☐ Google
- ☐ Yahoo
- ☐ Yelp
- ☐ Other: ______________
- ☐ Patient Referral: ______________
- ☐ Friend: ______________
- ☐ Dr. Referral: ______________
- ☐ Insurance Co: ______________
- ☐ Inland Empire Magazine
- ☐ San Antonio Magazine
- ☐ Your Villa Magazine
- ☐ Daily Bulletin Newspaper
- ☐ X103.9

What is the nature of your visit/ Time frame of procedure? ______________

## Emergency Contact

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

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

## Insurance

Insurance Name (Primary): ______________ Cardholder Name: ______________

Insurance Name (Secondary): ______________ Social Security #: ______________

****Dr. Edward Park is not a provider of Covered California/Obama Care or any HMO plans****

## Additional Services of Interest

Other than the services for today's visit, what additional services would you like to learn about? Please check all that apply:

- ☐ Skin care advice
- ☐ Skin care products
- ☐ Injectable Treatments
- ☐ Juvederm / Restylane / Radiesse
- ☐ Facial fine lines / wrinkles
- ☐ Thin lips
- ☐ Labiaplasty
- ☐ Chemical Peel
- ☐ Make up
- ☐ Coolsculpt
- ☐ Fat Graft
- ☐ Brown spots / age spots / freckles
- ☐ Drooping brow
- ☐ Drooping eyelids
- ☐ Nose size or shape
- ☐ Facial fullness / drooping
- ☐ Mole removal
- ☐ Scar revision
- ☐ Neck wrinkles
- ☐ Breast size
- ☐ Abdominal area
- ☐ Hips
- ☐ Legs
- ☐ Facial contouring
- ☐ Body contouring
- ☐ Brazilian Butt Lift
- ☐ Length / fullness of eyelashes

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# Patient History

## DRUG ALLERGIES

Are you allergic to any drugs: ☐ Yes ☐ No

If yes, they are:
☐ Penicillin ☐ Codeine
☐ Sulfa ☐ Morphine
☐ Tetanus ☐ Demerol
☐ Erythromycin ☐ Tetracycline

Other: ____________________

## PRESENT MEDICATIONS

Do you take Aspirin? ☐ Yes ☐ No
Do you take diet pills, including Phentermine? ☐ Yes ☐ No
Are you on any medications at the present time? ☐ Yes ☐ No

Names of Medications & Dosages:

____________________
____________________
____________________

## MEDICAL HISTORY

Do you smoke? ☐ Yes ☐ No
If yes, how much:
Pregnant/Nursing ☐ Yes ☐ No

Have you ever had any diseases associated with the following?
**Please check all that apply:**

☐ Lungs ☐ Hepatitis ☐ Convulsions
☐ Asthma ☐ HIV ☐ Abnormal EKG
☐ High blood pressure ☐ Kidney ☐ Anesthesia problems
☐ Heart ☐ Diabetes ☐ MRSA
☐ Jaundice ☐ Tuberculosis ☐ Other: __________
☐ Liver ☐ Cancer __________

Do you or any of your family members have any bleeding disorders? ☐ Yes ☐ No
Have you ever had blood transfusions? ☐ Yes ☐ No
Reason: ____________________

## FAMILY HISTORY

| | Age(s) | Health |
|---|---|---|
| Mother | | |
| | | |
| Father | | |
| | | |
| Brothers | | |
| | | |
| Sisters | | |
| | | |
| Sons | | |
| | | |
| Daughters | | |

Have you had a hysterectomy? ☐ Yes ☐ No

Have you had a tubal ligation? ☐ Yes ☐ No

## DIAGNOSTIC SUMMARY

| | | Surgery Reason | Date |
|---|---|---|---|
| Have you had any operations? | ☐ Yes ☐ No | ____________ | ______ |
| | | ____________ | ______ |
| | | ____________ | ______ |
| Previous cosmetic surgery? | ☐ Yes ☐ No | ____________ | ______ |
| | | ____________ | ______ |
| | | ____________ | ______ |
| Have you had any other hospitalizations? | ☐ Yes ☐ No | ____________ | ______ |
| | | ____________ | ______ |

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

Patient Signature: ____________________ Date: __________

Patient Name: ____________________ DOB__________

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# HIPAA Information and Consent Form

Patient Name: ________________________________________________

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,_____________________________________ 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: ________________________

## Assignment and Release (for insurance patients only)

I, <personalinfo.firstname> <personalinfo.lastname>, have insurance coverage and assign directly to Edward H. Park, M.D. Medical Corporation 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: _______________________________________________________ Date: _______________________