Today's Date:_____

Signature Plastic Surgery & Aesthetics
Mark Kobayashi, MD and Eleonore Zetrenne, MD

NEW PATIENT FORM

(Please Print)

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:				

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 Signature Plastic Surgery & Aesthetics or insurance company to release any information required to process my claims.

Patient/Guardian Signature: **Date:**

Signature Plastic Surgery & Aesthetics
4716 Barranca Parkway
Irvine, CA 92604
T: (949) 387-1404 F: (949) 387-1523

INSURANCE COVERAGE STATEMENT

To Our Valued Patients:

We realize that some of our patients come to us through the Emergency Room, others referred by their physician or by a friend. This is to notify you that we are **not** contracted with any insurance plans.

To those Emergency Room patients, we cannot be responsible for what the hospital tells you since they do not know which doctors are contracted with which insurance carriers. By law we are not at liberty to ask the hospital if you are insured or not. We are there to perform a service on an emergent level. If you are covered by an HMO or IPA you must notify your Primary Care Physician and Insurance Company as soon as possible.

You are responsible for charges incurred for services rendered at the time you are seen. Our office will bill your insurance for reimbursement and/or payment as a courtesy; however **you are ultimately responsible for your bill in its entirety.** Your contract is between you and your insurance company.

We apologize for any hardship this may cause, but due to the constant changes with insurance carriers, the amount of reimbursement by some, and/or high deductibles, we do not find it feasible to sign contracts with them.

Please sign below acknowledging that you have read this statement.

_____ _____

Signature or Guarantor or Patient Date

Signature Plastic Surgery & Aesthetics
4716 Barranca Parkway
Irvine, CA 92604
T: (949) 387-1404 F: (949) 387-1523

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be issued and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1) Uses and Disclosures of Protected Health Information
Uses and Disclosures of protected Health Information
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

2) Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

3) Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

4) Healthcare Operations
We may use or disclose, as needed your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use sign-in sheet at the

registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. WE may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by law, Public Health issues as required by law, Communicable Diseases: health Oversight: Abuse Neglect: Food and Drug administration requirements: legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation. Research: Criminal Activity and national Security: Worker's Compensation: Inmates: required uses and Disclosures: Under the law, we must make disclosures to you and when required by the secretary of the Department of health Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other Permitted and required uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization at any time in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

5) Your Rights
Following is a statement of your rights with respect to your protected health information.

6) You have the right to inspect and copy your protected health information:
Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

7) You have the right to request a restriction of your protected health information:
This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information will not be restricted. You then have the right to use another healthcare Professional.

8) You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

9)You may have the right to have you physician amend your protected health information if we deny your request for amendment, you have the right to file statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

9) You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

10) Complaints

You may complain to us or to the secretary of health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14,2003

we are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice Of privacy Practices:

Print name_____

Signature_____ Date_____

PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Age: _____

Stated Height: _____ Stated Weight: _____ Primary Language: _____ Contact Person: _____

Telephone Numbers: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Procedure: _____ Date of Procedure: _____

Physician performing procedure: _____ Primary Care Physician: _____

Internist: _____ Last seen: _____ Cardiologist: _____ Last seen: _____

ALLERGIES and ALLERGY REACTIONS:

_____

_____

LIST PREVIOUS SURGERIES: Year Complications Type of Anesthesia

_____

_____

_____

_____

_____

_____

LIST PREVIOUS CARDIAC/MEDICAL PROCEDURES: angioplasty/stent placement, echocardiogram, stress test, pacemaker or defibrillator model/brand #, and where done

Procedure Year

_____

_____

_____

_____

Please check appropriate box in each section below:

CARDIOVASCULAR	Yes	No
Hypertension	☐	☐
Heart Attack – Date:_____	☐	☐
Coronary Artery Disease	☐	☐
Cardiomyopathy	☐	☐
Congestive Heart Failure	☐	☐
Arrhythmias i.e. A-Fib	☐	☐
Rheumatic Fever	☐	☐
Heart Valve problems	☐	☐
Heart murmur	☐	☐
Carotid Artery Disease	☐	☐

	Yes	No
Angina/Chest Pain	☐	☐
Pain or shortness of breath when walking 2 blocks or climbing 1 flight of stairs	☐	☐
High Cholesterol	☐	☐
Poor Circulation in lower extremities	☐	☐
Family history of heart disease (age of onset)	☐	☐

Father Mother Siblings

_____ _____ _____

PULMONARY	Yes	No
Asthma	☐	☐
COPD/Bronchitis/Emphysema (circle)	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐

	Yes	No
Blood clots in lungs or legs	☐	☐
Sleep Apnea	☐	☐
Chronic Cough	☐	☐
Oxygen Use	☐	☐

PATIENT HISTORY QUESTIONNAIRE

Addressograph

GASTROINTESTINAL	Yes	No
Hiatal Hernia	☐	☐
Ulcers/GERD/Gastric Reflux (circle)	☐	☐
Gallstones	☐	☐
Liver Disease	☐	☐
Hepatitis A, B or C	☐	☐

GENITOURINARY	Yes	No
Urinary Tract Infections	☐	☐
Kidney Stones	☐	☐
Prostate Disease	☐	☐
Penile Prosthesis	☐	☐
Dialysis	☐	☐

HEMATOLOGIC	Yes	No
Anemia	☐	☐
Bleeding Disorders	☐	☐
Blood Diseases i.e. Leukemia	☐	☐
Blood Transfusions	☐	☐
Easy Bruising	☐	☐

ENDOCRINE	Yes	No
Diabetes	☐	☐
Hypo/Hyperthyroidism	☐	☐
Hypoglycemia	☐	☐

NEUROLOGIC	Yes	No
Stroke/TIA's	☐	☐
Seizures	☐	☐
Multiple Sclerosis	☐	☐
Myasthenia Gravis	☐	☐
Paralysis	☐	☐
Muscle Weakness	☐	☐
Headache	☐	☐
Fainting	☐	☐
Numbness	☐	☐

PAIN	Yes	No
Rheumatoid arthritis	☐	☐
Osteoarthritis	☐	☐
Chronic Pain Treatment	☐	☐
Back/Neck Pain	☐	☐
Artificial Joints	☐	☐

Location: _____

GENERAL HEALTHCARE	Yes	No
Cancer	☐	☐
Location: _____		
Radiation Therapy	☐	☐
Chemotherapy	☐	☐
Immune Deficiency	☐	☐
Measles/Mumps/Rubella (circle)	☐	☐
Chicken Pox	☐	☐
Have you had:		
MMR Vaccine	☐	☐
Flu Vaccine – Date: _____	☐	☐
Pneumonia Vaccine – Year: _____	☐	☐
TB Skin Test	☐	☐
☐ Positive ☐ Negative ☐ Unknown		

	Yes	No
Social History:		
Do you drink alcohol? Amount: _____	☐	☐
Do you smoke?	☐	☐
Did you ever smoke? Years: _____	☐	☐
Have you smoked in the past 12 months?	☐	☐
Do you use recreational drugs?	☐	☐
Type: _____		
If female: possibility of pregnancy?	☐	☐
Last menstrual period: _____		
History of Malignant Hyperthermia (MH)	☐	☐
Family history of anesthesia problems or MH (circle)	☐	☐

SURGICAL INFORMATION	Yes	No
Do you have any specific needs?	☐	☐
Hearing	☐	☐
Vision	☐	☐
Living alone	☐	☐
Transportation	☐	☐
Insurance	☐	☐
Do you exercise?	☐	☐
Type: _____		

	Yes	No
Do you need information on:		
Current surgery	☐	☐
Medications	☐	☐
Activities	☐	☐
Home Care	☐	☐
Do you wear contact lenses?	☐	☐
Do you have caps, bridges, dentures or loose teeth?	☐	☐

_____ [Patient/Parent/Conservator/Guardian]

_____ [If completed by other than patient, indicate relationship]

_____ [Date]

THIS SECTION FOR HOAG FACILITY PERSONNEL USE ONLY

_____ [Reviewed by Assessment Nurse] _____ [Date] _____ [Time]

_____ [Reviewed by Procedure Nurse] _____ [Date] _____ [Time]

_____ [Reviewed by PACU Nurse] _____ [Date] _____ [Time]

_____ [Reviewed by Discharge Nurse] _____ [Date] _____ [Time]