



Patient Information

Neil T. Chen, MD, Medical Director

Aesthetic Surgery ♦ Surgery of the Hand ♦ Plastic and Reconstructive Surgery

Last Name: _____ First Name: _____ Mid. Init. _____ Soc Sec #: _____
 Date of Birth _____ Age _____ Occupation _____ Referral by _____
 Address: _____ City _____ State _____ Zip _____
 Phone (home) _____; (work) _____; (mobile) _____ Circle the best contact number
 May we text you / email you appointment reminder? Y / N
 e-mail _____ May we email you future office events/promotions? Y / N
 Person to contact in an emergency _____ Phone _____ Relation _____
 Family physician _____ When was your last physical exam? _____

Primary Insurance _____ Policy holder _____ Policy number _____ Address_Phone _____ Contact_Authorization by _____ No. of visits _____ Secondary Insurance _____ Policy holder _____ Policy number _____ Address_Phone _____ Contact _____

By signing below:

I verify that the information I provide is complete, true, and correct to the best of my knowledge
 I agree to comply fully with my care, instruction, treatment and medication prescribed to me
 I authorize the release of medical information to and from Dr. Chen deemed medically necessary for my treatment.
 I agree to be responsible for all financial charges incurred as a result of my evaluation and treatment. Outstanding
 balance after 60 days is subject to monthly finance charge of 1.5% per month. I understand that the cost of collection
 in case of delinquency (90 days past due) will be added to my account.
 I agree that a copy of this document bearing my signature has the same effect as the original

Patient signature _____ **Date** _____

<p align="center"><u>Acknowledgement of Receipt of HIPPA Policy</u></p> <p>I hereby acknowledge that I have read and have the opportunity to receive a copy of this practice’s Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment. Enter email address if you would like to receive a copy of amended Notice of Privacy by e-mail:</p> <p>If not signed by patient, indicate relationship: __ parent or guardian of minor patient, __ guardian or conservator of an incompetent patient</p> <p>Patient signature _____ Date _____ (Please fill out other side)</p>

History Intake Form

Patient name: _____ *Height* _____ *Weight* _____

Reason for visit _____

Medications (including non-prescription drugs, vitamins and herbals): _____

Drug allergies: _____

List previous surgeries or major illness and dates: _____

Past Medical History: *Have you ever had the following?*

<i>Heart attack</i>	<i>yes</i>	<i>no</i>	<i>Stomach ulcer</i>	<i>yes</i>	<i>no</i>	<i>AIDS or HIV+</i>	<i>yes</i>	<i>no</i>
<i>Heart murmur</i>	<i>yes</i>	<i>no</i>	<i>Acid reflux</i>	<i>yes</i>	<i>no</i>	<i>Smoking</i>	<i>yes</i>	<i>no</i>
<i>Hypertension</i>	<i>yes</i>	<i>no</i>	<i>Rheumatoid disease</i>	<i>yes</i>	<i>no</i>	<i>Wear contact lenses</i>	<i>yes</i>	<i>no</i>
<i>Stroke</i>	<i>yes</i>	<i>no</i>	<i>Keloid scar</i>	<i>yes</i>	<i>no</i>	<i>Seizures</i>	<i>yes</i>	<i>no</i>
<i>Asthma</i>	<i>yes</i>	<i>no</i>	<i>Cancer</i> _____	<i>yes</i>	<i>no</i>	<i>Fever Blisters</i>	<i>yes</i>	<i>no</i>
<i>Diabetes</i>	<i>yes</i>	<i>no</i>	<i>2+ alcoholic drinks/day</i>	<i>yes</i>	<i>no</i>	<i>Pain syndrome (RSD)</i>	<i>yes</i>	<i>no</i>
<i>Thyroid disease</i>	<i>yes</i>	<i>no</i>	<i>6+ cups coffee /day</i>	<i>yes</i>	<i>no</i>			
<i>Bleeding tendency</i>	<i>yes</i>	<i>no</i>	<i>Hepatitis</i>	<i>yes</i>	<i>no</i>			

For **WOMEN** only:

Number of pregnancies: _____; *Number of children* _____

Is there any chance you may be pregnant? *Yes* *No*

Date of last mammogram: _____, *results:* *normal* *abnormal*

I verify that the above information is true and accurate to the best of my knowledge

X _____

Signature

_____ Date