# *Patient Information*

***Neil T. Chen, MD, Medical Director***

***Cosmetic Surgery ♦ Plastic and Reconstructive Surgery***

*Last Name:___________________________________First Name:__________________Mid. Init._*

*Date of Birth_______________________Age________Occupation___________________________*

*Referral by ( ) friend/family __________ ; ( ) web research; ( ) doctor ________; ( ) magazine; ( ) other __________*

*Address:_________________________________________________________________________________*

*City_________________________________________________________State__________________Zip_______*

*Phone (home)________________; (work)_________________; (mobile)________________ Circle the best contact number*

*Preference of appointment reminder: __ email, or __ text messaging: cell phone carrier: ___________________________*

*e-mail________________________________________________ May we email you reminder/ communication? Y / N*

*Person to contact in an emergency_______________________Phone________________________Relation_____________*

*Family physician ______________________________________ When was your last physical exam? __________________*

*Topic for consultation today:________________________________*

**Acknowledgement of Receipt of HIPPA Policy**

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:
If not signed by patient, indicate relationship: __ parent or guardian of minor patient, __ guardian or conservator of an incompetent patient

*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 acknowledge that there is a non-refundable and non-transferable scheduling fee when you book a surgical procedure. There is possible cancellation fee as described in the "Quote" document which you will receive.*
*I waive my privacy right under HIPPA for the verification of service provided to the third party payer if financial disputes arise.*
*I further acknowledge all refunds for funds paid with credit cards are subject to deduction of processing fees of 2.5%.*
*I agree that a copy of this document bearing my signature has the same effect as the original*

***Patient signature*__________________________________________*Date*_________________________**

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Do not write below – Office use only – version 04.09.2017

## Pre-Op Questionnaire

NAME: ______________________________________ DOB: ____/_____/____ Height _______Weight______

Medications including herbals ______________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Allergies: _____________________________________________________________________________________

Past Surgeries/Hospitalizations: ____________________________________________________________________

______________________________________________________________________________________________

For women only: # pregnancy ___; # children ___ Last mammogram: date _____; results _________

**History of patient/family difficulties with anesthesia:** _____________________**Malignant Hyperthermia?**____________

Activity Level (please check each that you are able to accomplish):

( ) Light Housework ( ) Heavy Housework ( ) Lifting ( ) Walking 20 min ( ) Climb 2 flights of stairs

**Medical History** (please check "yes" or "no" and circle appropriate conditions)

| Yes | No | |
|---|---|---|
| | | Do you smoke: ______ Pack per day ________ for ____________ years. Quit for ________________ |
| | | **Sleep Apnea**/ Difficult intubation with previous surgery / CPAP USE |
| | | Orthopedic problems / Osteoarthritis / Pheumatoid (Neck or Jaw affected? ) / TMJ |
| | | Recent pneumonia / Bronchitis / Cold |
| | | Asthma - Triggered by ______________________________ |
| | | Emphysema / Home 02 / What makes you short of breath? ________________________________ |
| | | Hypertension How Long? ________________________________________________________ |
| | | Chest Pain / Angina / Pleurisy / Congestive Heart Failure/Stents |
| | | Heart Attack When? _____________ Treated with _______________ Where _________________ |
| | | Heart Rhythm Problems / Palpitations Treated with __________________ Where _______________ |
| | | Pacemaker / AICD Placed at which hospital? __________________________________________ |
| | | Valvular Disease / Murmur (do you take antibiotics for dental procedures?) ( ) Yes ( ) No |
| | | Stroke / TIA When? _________________________ Any residual deficit ______________________ |
| | | Seizure / Headaches / Migraine Frequency _______________________ Duration ________________ |
| | | Chronic Pain: Sites __________ Pain (0 to 10) ____ Relieved/Improved by _____________________ |
| | | Muscular Disease / Dystrophy / Cerebral Palsy |
| | | Mental Health History (Anxiety / Depression) |
| | | Gastrointestinal problems / Liver problems / Hiatal Hernia / Acid Reflux or GERD |
| | | Alcohol Use ( ) Yes ( ) No Alcohol Abuse ( ) Yes ( ) No Recreation Drug? ________ When? ______ |
| | | Diabetes ( ) type I ( ) type 2 How long? ________________ |
| | | Hyper/Hypothroid Any recent change in dose of medicine or symptoms |
| | | Kidney Problems / Dialysis |
| | | Bleeding Problems / Anemia / PKU / Blood clots / History of transfusions / Sickle Cell Disease |
| | | Tuberculosis / HIV or AIDS / Hepatitis / STD's / History of Isolation |
| | | Cancer / Radiation / Chemotherapy When? ______________________________________________ |
| | | Congenital Defects / Prematurity / Neonatal Problems |
| | | Last Menstrual Period? _______________________ Chance of Pregnancy? ( ) Yes ( ) No |
| | | Out of country in last 3 months |

Please sign below to demonstrate you have answered the following questions to the best of your ability

Signature: ____________________________________________ Date: __________________________