PLASTIC SURGERY VEGAS

EDWARDS • HIGGINS • SILVER • TAM

What Would You Like to Talk About Today?

Patient's Name _____ _____ _____

Last First Date

What are your main concerns for today's visit?

_____

_____

_____

Please check the problem areas that concern you. Include anything you wish to discuss, even if it is not the main reason for your visit.

Face/Eyes/Neck

- ☐ Aging Face/Neck
- ☐ Aging brow/Forehead
- ☐ Excess Eyelid skin
- ☐ Botox
- ☐ Facial Fillers

Ears

- ☐ Prominent Ears
- ☐ Ear lobes

Nose

- ☐ Difficulty Breathing
- ☐ Shape or bump

Breasts

- ☐ Breast Augmentation
- ☐ Breast Asymmetry
- ☐ Breast Lift
- ☐ Breast Reduction
- ☐ Breast Implant Revision
- ☐ Breast Implant Removal
- ☐ Nipple/Areolar Concerns
- ☐ Male Breast Reduction
- ☐ Pectoral Implants (Men)

Gynecological

- ☐ Labiaplasty

Liposuction

- ☐ Abdomen
- ☐ Hips/flanks
- ☐ Bra Rolls
- ☐ Thighs
- ☐ Knees
- ☐ Calves
- ☐ Arms

Excess Skin

- ☐ Abdomen
- ☐ Thighs
- ☐ Arms

Skin Care/Dermatology

- ☐ Wrinkles/Fine lines
- ☐ Skin texture/pigment
- ☐ Laser treatment
- ☐ Chemical Peels
- ☐ Acne
- ☐ Moles
- ☐ Scars
- ☐ Rashes

Provider Recommendations (For Doctor to Complete):

_____

_____

_____

_____

I verify that I have provided all of my medical and surgical history to ensure my physician has all the important information to provide the safest care. I will update any new information that occurs in-between visits to include new diagnoses, new medications, subsequent surgeries and any hospitalizations.

_____ _____

Signature Date

8530 W. Sunset Road, Suite 130, Las Vegas, NV 89113 Office: 702.822.2100 Fax: 702.822.2105
www.PlasticSurgeryVegas.com

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Medical + Surgical History

Patient's Name _____ _____ _____

Last First Date

Height: _____ Weight: _____ DOB: _____ Age: _____

Have you had any previous plastic surgery? ☐ Yes ☐ No Were you satisfied with your results? ☐ Yes ☐ No

List **ALL** previous surgeries and approximate dates: _____

_____

_____

_____

Who is your Primary Care Physician? _____ Last Exam? _____

What Specialists do you see? _____

List **ALL** medications you take (include prescriptions, over the counter, vitamins, supplements, herbs, etc.):

_____

_____

_____

Describe **ALL** allergies and what occurs during the reaction (include prescriptions, over the counter, vitamins, supplements, herbs, etc.):

_____

_____

_____

Do you smoke, vape or use any form of nicotine including patches? ☐ Yes ☐ No

Number of years? ____ Packs/Amount per day? _____ If you quit smoking, when did you quit? _____

Do you smoke or ingest Marijuana products? ☐ Yes ☐ No How often/amount: _____

Do you drink alcohol? ☐ Yes ☐ No How often/amount: _____

Do you take aspirin, NSAIDS, (Motrin, Ibuprofen, Aleve, Advil) ☐ Yes ☐ No How often? _____

Have you ever been told you need antibiotics for a heart murmur? ☐ Yes ☐ No

Do you have any implanted devices (implants of any kind, pacemaker, joints, shunts or pump? ☐ Yes ☐ No

Any personal or family history of bleeding or clotting disorder (DVT= deep vein thrombosis, PE= pulmonary embolism):

☐ Yes ☐ No Explain: _____

Any personal or family history of breast cancer? ☐ Yes ☐ No Who?_____

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Medical + Surgical History Continued

Patient's Name _____ Last _____ First _____ Date

Are You Currently Taking: ☐ Birth Control Pills ☐ Hormone Replacement (Testosterone, Growth Hormone, Estrogen)
Are You Currently: ☐ Menopausal ☐ Peri-Menopausal ☐ Still Menstruating
Could You Be Pregnant? ☐ Yes ☐ No
Number Of Pregnancies: _____ Number Of Births: _____ Unexplained Miscarriages: _____
Tubal Ligation? ☐ Yes ☐ No Hysterectomy? ☐ Yes ☐ No
When Was Your Last Mammogram? _____

Check below if you have now **or** have ever had in the past any of these conditions or symptoms:

- ☐ Diabetes
- ☐ Weight loss/gain
- ☐ High Blood Pressure
- ☐ Heart Disease Heart
- ☐ Murmur
- ☐ MVP
- ☐ Rheumatic Fever
- ☐ Circulation Problems
- ☐ Stroke
- ☐ Lung Disease
- ☐ Asthma, Emphysema
- ☐ Persistent Cough
- ☐ Tuberculosis
- ☐ Night Sweats
- ☐ Bloody Sputum
- ☐ Abnormal Chest X-ray
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Gall Stones
- ☐ Ulcers
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Gastric Problems
- ☐ Melanoma
- ☐ Prescription drug problem
- ☐ Non-prescription drug problem
- ☐ Skin Cancer
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Keloids
- ☐ Cold Sores/Herpes
- ☐ Ever taken Accutane
- ☐ Steroid Therapy
- ☐ Poor Wound Healing
- ☐ Bleeding Disorder
- ☐ Epilepsy/Seizures
- ☐ Thyroid Problem
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Bulimia
- ☐ Anemia
- ☐ Cancer
- ☐ Depression
- ☐ Anxiety
- ☐ Glaucoma
- ☐ Ever taken Phen-phen
- ☐ Serious Dry eyes
- ☐ Alcoholism

Is there anything else we should know about you?

_____

_____

_____

_____

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Patient Registration Information

Patient's Name _____ _____ _____
Last First Date

Birthdate: _____ Age: _____ Gender: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Single ☐ Divorced

E-mail: _____

Address: _____
Street & Apt # City State Zip

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Which phone do you prefer we use to contact you? ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Any restrictions for contacting you? (Ok to call at work? Leave message at home?,etc.) _____

May we use your email to send useful information, updates, promotions and event info? We promise not to abuse it! ☐ Yes ☐ No

We offer 2 methods of appointment reminders, please check your preference (one): ☐ Text Message ☐ Email

For minors, who is the authorized adult or responsible party? _____

Patient's Employer: _____ Occupation: _____

Address: _____
Street & Suite # City State Zip

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

Address: _____
Street & Apt # City State Zip

Insurance Information

Do you have medical insurance? ☐ Yes ☐ No Insurance Provider _____

*Although we do not take insurance, this information will assist in coordinating your care.

Pharmacy Information

In the event we need to send a prescription to your pharmacy electronically, please provide your pharmacy information:

Pharmacy _____ **Cross Streets** _____ **Phone** _____

Referral Information

Who referred you to our practice? _____

May We Thank Them Using Your Name? ☐ Yes ☐ No

If Not Referred How Did You Hear About Us? ☐ Website _____ ☐ Magazine _____

☐ Other : _____

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Authorization & Acknowledgement

____ I consent to examination and general treatment by the physicians/practitioners of this office. Other consents will be required for specific procedures.

____ I understand that office charges are payable on the day of service.

____ I understand that photography is a necessary part of planning and evaluating for recommendations and treatments. I authorize the taking of photographs. These photographs will be used for documentation and planning only. An additional consent will be required for any other use.

Insurance Information (Required by Law)

Please note that the office is required to have all patients sign an agreement that they understand that our office has opted out of Medicare. Our provider's **have been excluded** from Medicare under 1128, 1156, or 1892 of the Act. In addition, our office is not contracted with any private insurance companies.

____ I understand that no payment from Medicare shall be received by either myself, my beneficiary, or any physician/practitioner of this office for any services renders. I accept full responsibility for payment for all services or items furnished.

____ I understand that no Medicare limits apply to what will be charged for items or services furnished by any physician/practitioner of this office.

____ I agree not to submit a claim to Medicare or to ask any physician/practitioner of this office to submit a claim or other documentation to Medicare on my behalf.

____ I understand that I am entering into this contract knowing that I have the right to obtain Medicare-covered items and services from physicians.practitioners who have not opted out of Medicare and that I am not compelled to enter into a contract such as this with physicians/practitioners who have opted out.

____ I understand that the office and its physicians/practitioners have opted out from Medicare for a period of two years, at which time, they will continue to request to opt-out.

____ I understand in cases of emergency that I am not required to enter into such an agreement and that emergency care may be provided if necessary. The services provided at this office are considered cosmetic however, and the nature of this practice is non-emergent.

____ I understand this document will be updated annually and be kept as part of my medical record so long as required by the State of Nevada. It will be made available to the Center for Medicare & Medicaid Services in the event a copy of this agreement is requested.

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____ In addition to all of the items above related to Medicare, I understand that no payment from any private insurance company shall be received or accepted by the office for any services rendered.

____ I understand that at no time will prior authorization, claims, or documentation be submitted from the office to my insurance company on my behalf.

____ I understand the office will not accept any contracted rate or deduction in payment and that I am fully responsible for the charges for any service or item given by the physician/practitioner.

IRS & Cash Reporting (Required by Law)

____ I understand the office is required to file Form 8300 with the IRS for all patients who pay $10,000 or more in cash during the year for single or related medical procedures. When used for medical care, cash means currency and coins, not cashier's checks, bank drafts, traveler's checks, money orders or personal checks. For more information: http://www.irs.gov/Business/Small-Businesses-&-Self-Employed/FAQs-Regarding-Reporting-Cash-Payments-of-Over-10000-Form-8300

Notice of Privacy Practices (Required by Law)

____ I understand that the office has Privacy Practices in place that provides information about how they may use and disclose my protected health information. I have the right to receive and review the Notice before signing this acknowledgment. As provided in the Notice, if any terms change, an updated copy will be made available online and in the office.

It is alright to communicate information about me/my appointments, test results, etc. with the following individuals:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

By signing this form, I acknowledge that I understand the general policies regarding treatment, insurance, cash and my protected health information. I may request a copy of this notice.

Signature	Date
Witness	Date

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Notice of Privacy Practice
Information Regarding Your Confidential Health Information
(Required By Law)

PATIENT RIGHTS

This document provides information about how we may use and disclose protected health information about you.

RESTRICTIONS

You have the right to request restrictions on certain uses and disclosures of your health information. Our practice will make every effort to honor reasonable restriction preferences.

CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you in a certain way. We will make every effort to honor your reasonable requests for confidential communications.

INSPECT AND COPY YOUR HEALTH INFORMATION

You have the right to read, review and receive a copy of your health information, including your complete chart and billing records. If you would like a copy of your health information, please let us know. We may charge you a reasonable fee to duplicate and assemble your copy.

AMEND YOUR INFORMATION

You have the right to ask us to update or modify your records if you believe your health records are incorrect or incomplete. We will be happy to accommodate you so long as this office maintains this information. In order to standardize this process please provide us with your request in writing and describe your reason for change. Your request may be denied if the health information was not created by our office, is not part of your records, or if the records containing your health information are determined to be accurate and complete.

DOCUMENTATION OF HEALTH INFORMATION

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations.

REQUEST A PAPER COPY OF THIS NOTICE

You have the right to obtain a copy of this notice of Privacy Practices directly from our office at any time.

POLICY AND PROCEDURE

We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our Notice. If we change our privacy practices, we will be sure our patients have access to a copy of the revised notice online and in our office.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. Please let us know of your concerns or complaints in writing.

In connection with the medical services received from Plastic Surgery Vegas, and its medical staff, information concerning our patient's medical conditions and treatment will only be disclosed as required to:

A. Any third-party payer covering medical services of the patient;
B. Other health care professionals and institutions involved in the delivery of health care to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
E. Pharmacies
F. As otherwise required by law

WITH AUTHORIZATION

Other than where Federal, State or local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization at any time, except to the extent that we have already made a use or disclosure based upon your authorization.

VERBAL AUTHORIZATION

We may also use or disclose your information to care givers or family members that are directly involved in your care with your verbal permission.