Health History

Name: _____ Birthday: _____ Date: _____

Social: Age_____ Sex: Male ☐ Female ☐ Marital Status_____ Occupation_____

Responsible Adult to Assist During Recovery Period_____ Relationship_____

Habits: Do you, or have you ever used any drugs for recreational purposes? **Yes/ No** Marijuana **Yes/ No**

Cocaine **Yes/ No** Methamphetamines **Yes/ No** Other (specify):_____

Do you currently smoke? **Yes/ No** If yes, how much? _____

Did you ever smoke? **Yes/ No** If yes, How long? _____ How much? _____

When did you quit?_____

Describe your alcohol consumption (How many drinks each day/week) _____

Describe your coffee/tea/cola consumption (How many each day/week)_____

Medications you are presently taking: None ☐ OR, list dosage and how frequently you take the medicine

Prescription Drugs	Non-Prescription (Vitamins; Herbs)
_____	_____
_____	_____
_____	_____
_____	_____

Are you or have you taken:

Aspirin **Yes/ No** Dosage and Frequency: _____

Accutane in the last 6 months **Yes/No** Dosage and Frequency: _____

NSA (Advil, Motrin, Ibuprofen, Aleve, Relafen, Naprosyn) **Yes/ No** Dosage and frequency:_____

Steroids or Cortisone Injections **Yes/ No** Dosage and Frequency: _____

Coumadin or Plavix **Yes/ No** Dosage and Frequency: _____

Anti-depressants **Yes/ No** Dosage and Frequency: _____

Allergies: None ☐ OR, please list any medications you are allergic to: _____

Are you allergic to: Adhesive tape? **Yes/ No** Iodine? **Yes/ No** Latex? **Yes/ No**

FOR WOMEN ONLY: Do you take estrogens (creams, shots, pills) or birth control pills? **Yes/ No** If "Yes"

Specify:_____

Family History

Have any blood relatives ever had any of the following problems? (circle)

Abnormal Bleeding **Yes/ No**	Coronary Surgery **Yes/ No**	Kidney Disease **Yes/ No**
Abnormal Clotting **Yes/ No**	Diabetes **Yes/ No**	Other Serious Illness **Yes/ No**
Anesthesia Problems **Yes/ No**	Heart Attack **Yes/ No**	
Cancer **Yes/ No**	Hypertension **Yes/ No**	

Please describe questions with a "Yes" answer: _____

What is the purpose of this consultation (describe what you would like corrected by plastic surgery and what our aesthetic goals are in regard to your desired correction)? _____

_____

Have you ever consulted a plastic surgeon? **Yes/ No** (Please Describe) _____

Have you ever had plastic surgery? **Yes/ No** (Please Describe): _____

_____

Have you ever been in litigation with a physician? **Yes/ No** (Please Describe): _____

_____

Personal Past History

Past Operations: None ☐ OR, list any past operations with the approximate date of surgery, your age at the time of operations, and name of the physician and hospital (include minor operations such as tonsillectomy)

Date	Age	Operation	Physician and Hospital

Past Illnesses/ Hospitalizations: No serious past illnesses ☐OR, list below with age:

Age	Illness/ Hospitalization

Have you ever had:

Abnormal bleeding **Yes/ No**
Abnormal clotting **Yes/ No**
Acid Regurgitation **Yes/ No**
Anemia **Yes/ No**
Angina **Yes/ No**
Asthma or Bronchitis **Yes/ No**
Diabetes **Yes/ No**
Fainting Spell **Yes/ No**
Heart Attack **Yes/ No**
Hepatitis **Yes/ No**
Hypertension **Yes/ No**
Sleep Apnea **Yes/ No**
Snoring **Yes/ No**
Weight Change past 12 Mo **Yes/ No**
Other Serious Illness **Yes/ No**

Please describe questions with a "Yes" answer: _____

Preoperative Screening: Adverse effect to any anesthesia? **Yes/ No** If "Yes" please specify: _____

_____

Do you wear:

Eye Glasses: **Yes/ No** Hearing Aid: **Yes/ No** Partials: **Yes/ No** If "Yes", Removable **Yes/ No**
Contact Lenses: **Yes/ No** Dentures: **Yes/ No**

Do you have: Caps: **Yes/ No** Veneers: **Yes/ No**

Are you in good health? **Yes/ No** Do you heal well? **Yes/ No**

Do you have long-standing emotional disorders? **Yes/ No**

Do you have a physician you call or visit for medical problems? **Yes/ No**

Name:_____ Address:_____

Phone:_____ May I consult, if necessary, with your physician? **Yes/ No**

Are there any additional health factors in your history that have not been covered in this medical history form?

_____

_____

Who may we thank for referring you to our office? _____

DANIEL C. MILLS, M.D. F.A.C.S.
AESTHETIC PLASTIC SURGERY

Personalized Cosmetic Questionnaire

Patient Name: _____ **Date:** _____

If you have any specific cosmetic interests, please check all that apply.

- ❑ Fine lines and wrinkles
- ❑ Skin texture
- ❑ Uneven skin tone / discoloration
- ❑ Sagging skin/volume loss
- ❑ Acne
- ❑ Eyelashes (longer, fuller, darker)
- ❑ Lip enhancement
- ❑ Botox®
- ❑ Juvederm™/ Radiesse®
- ❑ Unwanted hair/Laser Hair Removal
- ❑ Facelift
- ❑ Neck rejuvenation
- ❑ Eyes (drooping eyelids, tired)
- ❑ Nose (size, shape)
- ❑ Body Liposuction
- ❑ Breast shape, size (drooping, sagging)
- ❑ Abdomen (muffin top, extra skin)
- ❑ Interest in surgical consultation with Dr. Mills

Other_____

_____

_____

Aesthetic Plastic Surgical Institute, Inc. strives to maintain high standards of confidentiality over your health care information. As such, we feel it is important to ask you to designate your preferences in disclosing your health care information.

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care options). If none, please indicate so.

_____

_____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____ Phone #_____
Name_____ Phone #_____

3. Please print the address you would like your billing statements and/or correspondence from our office to be sent if other than your home.

Street_____
City, State, ZIP_____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": Yes_____ No_____

5. Please print the telephone number where you want to receive calls about your appointments, lab and ex-ray results, or other health care information if other than your home number: _____

(I am fully aware that a cell phone is not a secure and private line)

6. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? Yes_____ No_____

7. Please list an identifying password to verify identity should you call in to get your patient information. (Examples include your mother's maiden name or another word that you will remember.) Also, you could list a question that would enable you to cue that word, if you so desire.
_____

PATIENT NAME_____*(guardian if under 18 years)*

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

Acknowledgement of Receipt of Notice of Privacy Practices

Aesthetic Plastic Surgical Institute, Inc. reserves the right to modify the privacy practices outlined in the notice.

*Notice is posted in waiting room and reception area.

*Copy available upon request.

Signature _____

I have a read copy of the Notice of Privacy Practices for Aesthetic Plastic Surgical Institute, Inc.

_____

Name of Patient (Print)

_____

Signature of Patient

_____

Date

_____

Signature of Patient representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

CANCELLATION POLICY

At the Aesthetic Plastic Surgical Institute, Inc. and Monarch Bay Laser we strive to provide our patients with excellent service.

In order to meet our patients' needs we require a 24-hour notice for all cancelled and rescheduled appointments.

A $95.00 fee may be charged to those who are unable to provide at least a 24-hour notice of appointment change with a PA or an RN.

A $125.00 fee may be charged to those who are unable to provide at least a 24-hour notice of an appointment change with the surgeon.

All patient credits are void after 18 months.

Credit Card #_____

Name as it appears on card: _____

Expiration date: _____ CVV # _____

Thank you, for your cooperation.

Print Name_____Date / /

Signature_____

Patient Registration Form

Name: _____ Birthday: _____ Age: _____ Gender: _____

Current Address: _____ Marital Status: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Drivers License: _____ State: ____ Home Phone: _____

e-mail Address: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Would You Like to Receive the e-Newsletter ☐ Yes ☐ No What is your preferred method of contact? _____

Referred by:

☐ Physician _____ ☐ APSI Employee _____
☐ Patient Name _____ ☐ Hospital _____
☐ Salon _____ ☐ Seminar _____
☐ Internet (Which Site) _____ ☐ Media. Circle One: Article - Publication – Mailer

Responsible

Name: _____ DOB: _____ Relationship: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip: _____ Home Phone: _____ Work Phone: _____

Employer: _____ Address: _____

Insurance

Insurance Company Name: _____

Address: _____ State: _____ Zip: _____

Benefits Phone #_____ Preauthorization Phone #: _____

Insured's Name: _____

Insured's Address: _____

Policy #: _____ Group #: _____ Medicare #: _____

Insured's Signature: _____ Date: _____

- I hereby authorize Drs. Mills and Ryan and/or Aesthetic Plastic Surgical Institute, Inc. to release any information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance claim[s].
- I also hereby authorize and direct payment for the services rendered to me by Drs. Mills and Ryan to be made directly to Aesthetic Plastic Surgical Institute, Inc. and Oceanview Ambulatory Surgery Center. I understand I am financially responsible for all fees for the services rendered regardless of my insurance benefits, if any. A copy of this authorization shall be considered as valid as the original.
- I represent to the physicians and staff that I am 18 years of age or older, or if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.
- I consent to be photographed before, during, and after the treatment[s]. These photographs will be the property of Aesthetic Plastic Surgical Institute, Inc. and may be used for scientific and / or educational presentations or publications and shall be kept confidential.

_____ Date: _____

Signature [patient, parent/guardian]

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature Date

By: _____ _____
Physician's or Authorized Representative's Signature Date

By: _____
Print Patient's Name

Daniel C. Mills, M.D., F.A.C.S.
31862 Pacific Coast Hwy., Ste. 401
Laguna Beach, CA 92651

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.