**Physician Review** _____

**Anesthesia Review** _____

# Health History

Name: _____ Birthday: _____ Date: _____

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

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 per 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/Supplements) |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**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**

**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: _____

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

If "Yes" please specify: _____

Referred by: _____

## Family History

**Have any blood relatives ever experienced following problems? (circle)**

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

Unexpected death(s) following general anesthesia or exercise **Yes/No**

Family or personal history of Malignant Hyperthermia: **Yes/No**

Family or personal history of a Muscle or Neuromuscular Disorder: **Yes/No**

Please describe questions with a "Yes" answer: _____

_____

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 History:

**Have you ever experienced the following? (circle)**

| Date | Age | Operation/Illness/Hospitalization | Physician and Hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Abnormal bleeding **Yes/ No**
Abnormal clotting **Yes/ No**
Acid Regurgitation **Yes/ No**
Anemia **Yes/ No**
Diabetes **Yes/ No**
Fainting Spell **Yes/ No**
Heart Attack **Yes/ No**
Hepatitis **Yes/ No**
Snoring **Yes/ No**
Weight Change (past 12 mo) **Yes/ No**
Other Serious Illness **Yes/ No**
Angina **Yes/ No**

Hypertension **Yes/ No**
High temperature following exercise **Yes/No**

Asthma or Bronchitis **Yes/ No**
Sleep Apnea **Yes/ No**
Muscle Spasms **Yes/No**

Dark colored urine **Yes/No**
Unanticipated fever following anesthesia or serious exercise **Yes/No**

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

**Aesthetic Plastic Surgical Institute 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.**

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.

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 #_____

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

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

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

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.

_____

Please indicate if you have executed an advanced directive. If you have an advanced directive, please provide our office with a copy before your procedure. Yes_____ No_____

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

By signing below, I give permission to send me **text message reminders about my appointments** or other notifications at the phone number I have provided.

- I understand that text messaging is **not a secure form of communication**, and there is a risk that unauthorized persons could access the information in these message and may contain **limited personal information**. No detailed health information will be included in these messages.
- I understand that I can **opt out at any time** by notifying the clinic in writing or replying "STOP" to any text message received.

☑ I consent to receive text message reminders from APSI/OASC.

**Patient Name:** _____
**Mobile Number:** _____
**Signature:** _____
**Date:** _____

# Patient Registration Form

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

Current Address: _____ Marital Status: _____

City: _____ State: _____ Zip: _____ Ethnicity: _____

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 – Magazine

## Emergency Contact Information

Name: _____ DOB: _____ Relationship: _____

Address: _____

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

Employer: _____ Address: _____

## Pharmacy:

Pharmacy Name: _____ Pharmacy Phone: _____

## 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/or Aesthetic Plastic Surgical Institute, Inc. to release any information regarding services rendered by him/her and allows 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 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]

# PATIENT-PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: 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 right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
**Patient's Initials: _____**

ARTICLE 2: I understand and agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services 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. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including. without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this Agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the Medical Arbitration Rules of the California Medical Association and the California Hospital Association.
**Patient's Initials: _____**

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.
**Patient's Initials: _____**

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN 30 DAYS OF THE DATE OF MY SIGNATURE BELOW STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.
**Patient's Initials: _____**

ARTICLE 5: On behalf of myself and all others bound by this Agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Medical Association and the California Hospital Association, as they may be amended from time to time, which Rules are hereby incorporated into this Agreement. A copy of these Rules is included in the pamphlet in which this Agreement is found. Additional copies of the Rules are available from the California Medical Association, 1201 J Street, Suite #200 Attention: Publication Department, Sacramento, CA 95814 or at www.cmanet.org. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).
**Patient's Initials: _____**

ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT If I intend this Agreement to cover services rendered before the date this Agreement is signed (for example, emergency treatment), I have indicated the earlier date I intend this Agreement to be effective from as confirmed by my initials immediately below. Earlier effective date:
**Patient's Initials: _____**

ARTICLE 7: I have read and understood all of the information in this pamphlet, including the Introduction to the Patient Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient' as used herein means both the mother and the mothers expected child or children.
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.
**Patient's Initials: _____**

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 OF THIS CONTRACT.

_____ _____

**Patient Signature** **Date**

If signed by other than patient (legal guardian, parent or legal representative) indicate relationship: _____

PHYSICIAN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this Agreement and in the Rules specified in Article 5 above.

_____ Dated:_____, ___
(Physician or Duly-Authorized Representative)

_____ _____

Title—e.g., Partner, President etc. Printname of Physician,MedicalGroup, Partnership, or Association