NEW PATIENT INFORMATION

Today's Date ________________ • Male ☐ Female ☐ • Date of Birth (*mm/dd/yyyy*) ______________ • Age __________

Name: ____
(*first*) (*middle initial*) (*last*)

Address: ____
(*street*) (*city*) (*state*) (*zip code*)

Home Phone # (*land line*) : ______________________ Mobile #: ______________________ ☐ confirmation calls/texts?

Work #: ____________________ Occupation: ____________________ Employer: ____________________

Email: ____
(*we use email frequently to communicate appointment information and do NOT send solicited material*)

• Name of referring physician (*if applicable*): ____
• Referred from one of our existing patients? If so, we would love to know and show our appreciation!
Name: ______________________________ | Do we have your permission to send them a thank you card? ☐
• How did you hear about us if not from a particular person? ______ Internet ______ Overlake Weight Loss Center
______ Other ______ Evergreen Beauty College

Race (*check one if applicable*) **OPTIONAL**

______ Caucasion ______ Hispanic ______ East Indian
______ African American ______ Asian ______ NOT Hispanic or Latino

Language (*check all that apply*)

______ English ______ Spanish ______ Korean ______ Mandarin
______ Cantonese ______ Vietnamese ______ Russian ______ Other: ________________

Relationship/Marital Status:

______ Single
______ Married | Spouse - name: ______________________________ | *Also your emergency contact?* ☐
Spouse - phone #: ______________________________
*Other Relationship Status (*if you would like to include for your file*): ______________________________________

Emergency Contact: ________________ Phone: ____________________Relationship to you: ________________

INSURANCE

Primary Insurance Company: ______________________ ID# ________________ Group # ____________
Insured Name: ______________________________ DOB ________________ SS # ______________

Secondary Insurance Company: ______________________ ID# ________________ Group # ____________
Insured Name: ______________________________ DOB ________________ SS # ______________

I hereby authorize payment of any surgical and/or medical benefits directly to the physician for services. I also agree to pay all charges that exceed or are not covered by insurance and authorize release of information to the insurance company. I also authorize the physician to disclose information to those individuals qualified for the purpose of medical quality assurance and peer review.

Signature: ____ Date: ______________________________

HISTORY & PHYSICAL

Patient Name ____________________ Date of Birth: ___/___/______ Today's Date ____________________
Primary Concern(s) ____
PCP (primary care provider) ____________________ | Phone number: ____________________

Known Drug Allergies & Reactions ____

____

____

Latex Allergy (if known): Yes__________ | No__________

Have you ever had any of the following?

- ☐ Heart disease/Heart Murmur
- ☐ Mitral valve prolapse
- ☐ High blood pressure
- ☐ Phlebitis
- ☐ Hepatitis
- ☐ HIV
- ☐ Anemia
- ☐ Herpes (cold sore, genital or shingles)
- ☐ Diabetes
- ☐ Acid reflux disease
- ☐ Problems w/ anesthesia
- ☐ Asthma
- ☐ Sleep apnea/snoring
- ☐ Migraines/headaches
- ☐ Stroke/TIA
- ☐ Psychiatric care
- ☐ Arthritis
- ☐ Cancer (of__________)

Have you recently had any of the following?

- ☐ Fever, chills, nausea, vomiting or diarrhea
- ☐ Weight increase or decrease
- ☐ Skin rashes or lumps
- ☐ Frequent colds, sinus congestion
- ☐ Changes in vision or hearing
- ☐ Sore throat or bleeding gums
- ☐ Lumps in neck
- ☐ Breast masses, nipple discharge
- ☐ Chest pain or shortness of breath
- ☐ Difficulty breathing
- ☐ Numbness, tingling, cramping in hands or feet
- ☐ Swelling in the hands or feet
- ☐ Seizures, paralysis
- ☐ Anxiety
- ☐ Depression
- ☐ Heartburn or abdominal pain
- ☐ Other____________________

For our female patients:
# of pregnancies __________ | # of births__________ | most recent mammogram date ____________________

Previous surgeries/hospitalizations/illnesses & date(s):

____

____

____

Current medication(s)/treatment for & dosage information:

____

____

____

Significant family medical history:

____

____

GEORGE MIN MD | JAMES RIDGWAY MD • 10047 MAIN ST. #103 - BELLEVUE, WA 98004 • PH: 425.463.9883 • FAX: 425.968.4631

Alcohol Consumption:
___ I never consume alcoholic drinks
___ I occasionally consume alcoholic drinks | approximately _______ drinks(s) per week/month
___ I regularly consume alcoholic drinks | approximately _______ drinks(s) per week

Exercise/Activity Level ____
____

Type of Employment/Environment *(ie: full time desk job; construction; homemaker; etc…)*
____

I hereby declare that the information I have provided on this form is a true and accurate record to the best of my knowledge.

PATIENT SIGNATURE ____ Date ____________________

Reviewed/Witnessed by ____ Date ____________________

SMOKING RISK CONSENT

I have been advised by Dr. George Min/Dr. James Ridgway and his staff that I must not smoke or take nicotine substitutes for a ***minimum of six (6) weeks before my surgery***. I have also been advised that being in the presence of secondhand smoke can compromise my surgery and its outcome. It has been explained to me that the risks of surgery are much greater for smokers and even if I am off cigarettes AND all nicotine substitutes for six (6) weeks before and after surgery, I may still experience the effects of nicotine.

☐ I am NOT a smoker.
☐ I no longer smoke regularly. I quit __________weeks/months/years ago.
☐ I currently smoke __________________ a day.

There is greater risk in smokers for bad scarring, hematoma formation, intraoperative bleeding, bleeding, poor or delayed healing, hair loss, sloughing of the skin (skin loss), infection, increased or prolonged bruising and hyperpigmentation.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO OPERATE, THAT THE RISKS HAVE BEEN FULLY EXPLAINED TO ME AND I WISH TO PROCEED WITH SURGERY.

Patient Signature ____________________ Date _______ | Witness ____________________ Date ________

To be completed by RN:

VITALS: BP ______ HR ______ T ______ 02 sat ______ height ______ weight ______

AUTHORIZATION TO RELEASE INFORMATION

If requested, I, ____, authorize my information to be shared with:

(Patient Name)

1) Name ________________________________ Phone _________________________ Relationship _________________

2) Name ________________________________ Phone _________________________ Relationship _________________

3) Name ________________________________ Phone: _________________________ Relationship _________________

**NO ONE _________

Regarding the **initialed** items below, I understand that by signing this form only the person(s) designated above are allowed to obtain my information and they are **only** allowed to obtain information regarding the items that I have designated below. By **initialing** beside **"ALL INFORMATION"** I understand that the person(s) listed above will be granted access to obtain all of my medical and personal information that the office of Newvue Plastic Surgery has on file. I understand that this written authorization will remain in my permanent record and will not change at any time unless I issue a written consent to discontinue and/or change this authorization.

_______ APPOINTMENT DATES/TIMES | _______ TEST RESULTS | __________ INSURANCE INFORMATION |

_______ **ALL INFORMATION** | _______ OTHER:________________________

____

Patient Signature Date

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, ____________________________ whose signature appears below, authorize Newvue Plastic Surgery and its Affiliated Providers to view my external prescription history via our electronic health record system, eClinical Works.

I understand that prescription history from other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and authorized staff here, and it may include prescriptions dated back several years.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS TO MY PRESCRIPTION HISTORY.

____

Patient Signature Date

Please provide us with your preferred pharmacy information:

____

Pharmacy Name & Location Address *(if known)* Phone Number

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PLASTIC SURGERY | SKIN CARE

PATIENT PHOTOGRAPH RELEASE FORM

I hereby grant permission for Newvue Plastic Surgery and its designated representatives to take and use any pre-operative or post-operative photographs of myself for purposes of medical record, research, education and medical publications as well as advertising. I understand that no form of compensation shall become payable to me for the use of photographs. I further understand no names, birth dates or private information will be disclosed.

Patient Name (*please print*) ______________________________

Signature ______________________________ | Date ____________________

**If patient is under 18 years of age or requires signature of a legal guardian:

Name ______________________________ | Relationship to Patient ____________________

Signature ______________________________ | Date ____________________

ACKNOWLEDGMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review this office's *Notice of Privacy Practices* as required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Provide and coordinate treatment among health care providers who may be involved in my care
2. Obtain payment from third-party payers for my health care services
3. Conduct normal health care operations

Patient Name ______________________________ Date ____________________
(*Please Print*)

Signature ______________________________ Date ____________________

**If patient is under 18 years of age or requires signature of a legal guardian:

Name ______________________________ | Relationship to Patient ____________________

Signature ______________________________ | Date ____________________