TJD MD

TERRY J. DUBROW, M.D., F.A.C.S.

Patient First Name   Middle Initial   Last Name   Date

Address   City   State   Zip code

Home Phone   Cell Phone   Date of Birth   Age

Email   Referred By

Sex: M F   **Marital Status:** M S D W

Emergency Contact Name: ______________________________   Phone:________________________

With whom may we share your medical information? ____

May we leave a message at your home number?   YES   NO

♦♦♦

Complete this section if someone other than the patient is financially responsible.

Responsible Party Name   Relationship to Patient

Address   City   State   Zip code

Home Phone   Cell Phone   Date of Birth   Age

Social Security Number

Employer   Work Phone Number

Address   City   State   Zip code

♦♦♦

I authorize the payment of medical and surgical benefits to Terry Dubrow, M.D.

Signature of Patient or Responsible Party   Date

1617 Westcliff Drive, Suite 207♦ Newport Beach, CA 92660
Tel: (949)515-4111♦ Fax: (949)515-0318

Age _____ Weight _____ Height _____

Employer _____ Marital Status: _____

HEALTH INFORMATON

Personal Past History:

Do you have any chronic medical problems? (Circle all that apply)

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
	Asthma	Other _____

Is there a personal or family history of anesthetic complications? ☐ No ☐ Yes

If yes, please explain_____

Family History:

Do you have a family history of any medical problems? (Circle all that apply) Please indicate family member.

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
	Asthma	Other _____

Please list all prior operations:	Date	List any complications
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please list all prior Hospitalizations:	Date	List any complications
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please list **ALL** medications and/or dietary supplements including:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Please list **ALL** allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc).

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Social History:

Have you ever used tobacco products? ☐No ☐Yes If yes, how long? _____ how much? _____
Which tobacco product(s) have you used? _____
If you are a former smoker, state the year you stopped: _____

Past or current use of Nicotine Gum, Patch, or any other type of stop-smoking aid: ☐No ☐Yes
If yes, please list: _____

Alcohol Consumption: _____Never (Do not consume alcohol) _____ Rare (1-2 drinks a week)

_____ Moderate (7-10 drinks a week) _____ Heavy (daily or more than 10 drinks a wk)

Did you ever drink heavily in the past? ☐No ☐Yes

Are you feeling hopeless about the present/future? ☐No ☐Yes

Do you currently have thoughts of harming yourself? ☐No ☐Yes

Review of Systems:

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure	Y ___ N ____	Heart Failure	Y ___ N ____
Heart Attack	Y ___ N ____	Irregular Heartbeat	Y ___ N ____
Angina/chest pain	Y ___ N ____	Heart Murmur	Y ___ N ____
Heart bypass surgery	Y ___ N ____	Do you exercise?	Y ___ N ____
Pacemaker	Y ___ N ____	Comments: _____	

NEUROLOGICAL

Stroke	Y ___ N ____	Abnormal Chest X-ray	Y ___ N ____
Seizures	Y ___ N ____	Asthma	Y ___ N ____
Fainting	Y ___ N ____	Bronchitis	Y ___ N ____
Dizziness	Y ___ N ____	Emphysema	Y ___ N ____
Headache	Y ___ N ____	Recent Chest Infection	Y ___ N ____
Double Vision	Y ___ N ____	Shortness of Breath	Y ___ N ____
		Shortness of Breath at night	Y ___ N ____
PSYCHIATRIC		Shortness of Breath on exertion	Y ___ N ____
Depression	Y ___ N ____	Cough	Y ___ N ____
Anxiety	Y ___ N ____	Cough with Sputum	Y ___ N ____
Psychiatric Care	Y ___ N ____	Sleep Apnea	Y ___ N ____
Obsessive Compulsive Disorder	Y ___ N ____	-Use a C-PAP Machine	Y ___ N ____

ENDOCRINE

Diabetes	Y ___ N ____	MUSCULOSKELETAL	
Thyroid Disease	Y ___ N ____	Sciatica	Y ___ N ____
Taken Steroids	Y ___ N ____	Herniated disc	Y ___ N ____
		Arthritis	Y ___ N ____
		Rheumatoid	Y ___ N ____
		Neck, Back, Arm,Leg Prob	Y ___ N ____

HEMATOLOGIC/ONCOLOGIC/

Bleeding Tendency	Y ___ N ____	INFECTIOUS	
Easy Bruising	Y ___ N ____	GASTROINTESTINAL	
Anemia	Y ___ N ____	Jaundice	Y ___ N ____
Sickle Cell Disease	Y ___ N ____	Hepatitis	Y ___ N ____
Blood clots in legs	Y ___ N ____	Ulcers	Y ___ N ____
Blood clots in lungs	Y ___ N ____	Hiatal Hernia	Y ___ N ____
Radiation Therapy	Y ___ N ____	Heartburn	Y ___ N ____
		SKIN	
URINARY/REPRODUCTIVE		Basal cell skin cancer	Y ___ N ____
Kidney Disease	Y ___ N ____	Melanoma	Y ___ N ____
Urinary Disease	Y ___ N ____	Staph Infection	Y ___ N ____
Dialysis	Y ___ N ____		
If female, could you be preg?	Y ___ N ____	EYES	
Number of live births_____		Cataracts	Y ___ N ____
Number of pregnancies _____		Glaucoma	Y ___ N ____
Date of last mammogram _____			
Date of date of menses (period) _____			

Terry Dubrow M.D., F.A.C.S.
and Affiliated Associates

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.
This notice of Privacy Practices describes how we may use and disclose your protected health information
(PHI) to carry out treatment, payment and health care operations (TPO) and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information. "Protected heath information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health services.
Uses and Disclosures of Protected Health Information Your protected health information (PHI) may be used and disclosed by your Physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, support the operation of the physician's practice, and any other use required by law.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by your name in the waiting room when your physician is ready to see you. We may disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Heath issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Directors, and Organ Donation: Research, Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: required Uses and Disclosures: Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to Investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that you physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your rights: Following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected health information: Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal or a administration action or proceedings, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of you protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location: You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend you protected health information: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information:

We reserve the right to change terms of this notice and will inform you by mail of any changes, you then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by telephone at our main telephone number (949)515-4111.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____ _____

Patient Name Date

_____ _____

Witness Date

This Notice was published and becomes effective on/or before April 14, 2003

Terry Dubrow M.D., F.A.C.S

1617 Westcliff Drive Suite 207
Newport Beach, CA 92660

Refund Policy

In order to be very clear and upfront with his patients Dr. Dubrow wants to clarify his practice policy on refunds. As you have been made aware the science and art of plastic surgery involves the significant risks of complications. These complications like scarring, poor healing, infection, etc. (described to you in detail on your consent forms) occasionally can and do result in a poor outcome and in fact are often responsible for you looking WORSE from your surgical procedure rather than better. Although Dr. Dubrow has significant experience in plastic surgery he cannot and does not in any way guarantee that your procedure won't result in a poor outcome. This can and does occur despite performance of the procedure in an appropriate manner. Because of this significant risk, NO REFUNDS will be offered if you suffer a complication resulting in a poor outcome. In fact in order to repair the poor outcome of a procedure you may incur significant additional charges. Your signature below memorializes your clear understanding of our refund policy.

Date: _____ Signature: _____

Terry Dubrow M.D., F.A.C.S.
1617 Westcliff Drive Suite 207
Newport Beach, CA 92660

Warning Regarding HIPPA and Email/Text Communications

Dr. Dubrow and his practice takes every step possible to maintain your privacy and to stay compliant with all HIPPA laws. However at this time in technology it is not possible to ensure complete privacy between you and our practice for email and text communications. In other words if you are to text or email any of your medical information or photos to our practice it cannot be guaranteed that all of the information is compliant with HIPPA privacy laws and it is possible that some of it could be inadvertently exposed. For this reason we want to make clear that HIPPA compliance is not possible for all text and emails between you and either Dr. Dubrow or any of his staff and you should be warned of the possibility of sensitive information being unprotected. Your signature below memorializes your understanding of this important issue.

Date: _____ Signature: _____

Terry Dubrow M.D., F.A.C.S.
1617 Westcliff Drive Suite 207
Newport Beach, CA 92660

Out-of-Town Patient Memorandum

Dr. Dubrow and his staff appreciates that you have travelled from out of town to seek potential surgical services provided by Dr. Dubrow's practice. We would like to take this opportunity to clarify the unique situations that may arise from treating patients from out of town that may not initially be obvious.

As you should be aware plastic surgery involves procedures that carry substantial risks of complications that may require additional care. These complications such as infection,bleeding, scarring and many others often occur significantly after you have returned home. Because it is impossible to practice good patient care from a distance you may require further care in your home town. Although Dr. Dubrow's practice may be reasonably available for advice or support from a distance, should a complication or difficulty arise post-operatively, you will need to immediately seek your own medical care in your local area. Our practice will not be able to give sound medical advice from a distance. You need to understand that any expenses incurred as a result of your further treatment are your sole responsibility. Although at all times we strive to provide the best surgical and medical care possible, significant problems not infrequently occur in plastic surgery and the chance that you may require further care may be substantial.

Your signature below memorializes that you have read and understand this special concern for out of town patients.

Date: _____ Signature: _____