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: S M D W**

Occupation: ____

Emergency Contact Name:______________________________ **Phone**:________________________

With whom may we share your medical information? ____

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

Height __________ **Weight**___________ **Current Bra Size if Discussing Breast Procedure** ________

♦♦♦

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

Reason for visit

(Circle ALL that apply)

Tummy Tuck	Breast Augmentation	Breast Lift
Brazilian Butt Lift	Full Body Lift	Liposuction (to what area)_____
Arm Lift	Thigh Lift	Buttock Implants
Gynecomastia Repair	Facelift	Eyelid surgery (upper/lower/both)
Removal & Replacement of Breast Implants		Hernia repair
Rhinoplasty		

Other: _____

Past Personal History

Do you or have you had any of the following chronic medical conditions? (Circle ALL that apply)

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV/AIDS
Heart Failure	Psychiatric Diagnosis (depression, anxiety, etc.)	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attacks	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
Other _____	Asthma	

Do you have a personal history or a family history of anesthetic complications? ☐ No ☐ Yes

If yes, please explain_____

Family Health History

Do you have a family history of any medical conditions? (Circle ALL that apply)

Please indicate specific family member next to listed condition.

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

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 Medications, Aspirin, Vitamins, Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil, St. John's Wort, etc.)

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

Please list ALL allergies and describe reaction: (i.e. Shellfish = Anaphylactic shock, Latex = Rash, Penicillin =Severe Itching, etc.)

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

Social History

Tobacco

Have you ever used tobacco products? ☐No ☐Yes If yes, how long? _____ How much? _____

Do you or have you ever vaped or used electronic cigarettes? ☐No ☐Yes If yes, how long? _____
If you are a former smoker, state the year you stopped: _____

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

Drugs

Do you or have you used marijuana? ☐No ☐Yes If yes, how long? _____ How much? _____

Do you or have you ever used any illicit drugs? ☐No ☐Yes If yes, which kind? _____ How long? _____

Alcohol

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

Diet/Physical Fitness

How would you rate you eating habits? Poor Fair Good Excellent

Do you exercise? ☐No ☐Yes If yes, how often? _____ How long per session? _____

Have you experienced any weight gain/loss in the past 12 months? ☐No ☐Yes If yes, how much? _____ When? ____

Service Animal

Do you have a Service animal? □ No □ Yes If yes, what task has your animal been trained to perform?

_____

Mental Health

Have you ever been clinically diagnosed with a mental illness? ☐No ☐Yes If yes please list: _____

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

Do you or have you ever been clinically diagnosed with depression? ☐No ☐Yes

Do you or have you ever experienced intense emotions including; anxiety/panic attacks, isolation, loneliness, shame, worthlessness, or emotional withdrawal? ☐No ☐Yes If yes please list: _____

Do you frequently experience impaired reasoning including, but not limited to; rigid thinking, poor judgement/problem solving/decision making? ☐No ☐Yes

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

Do you or have you ever had thoughts of suicide? ☐No ☐Yes

Systems Review

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 Attack	Y ___	N ____
Angina/chest pain	Y ___	N ____
Heart bypass surgery	Y ___	N ____
Pacemaker	Y ___	N ____
Heart Failure	Y ___	N ____
Irregular Heartbeat	Y ___	N ____
Heart Murmur	Y ___	N ____
Do you exercise regularly?	Y ___	N ____

Comments: _____

NEUROLOGICAL

Stroke	Y ___	N ____
Seizures	Y ___	N ____
Fainting	Y ___	N ____
Dizziness	Y ___	N ____
Headache	Y ___	N ____
Double Vision	Y ___	N ____

PSYCHIATRIC

Depression	Y ___	N ____
Anxiety	Y ___	N ____
Psychiatric Care	Y ___	N ____
Obsessive Compulsive Disorder	Y ___	N ____
Emotional Support Dog:	Y ___	N ____

ENDOCRINE

Diabetes	Y ___	N ____
Thyroid Disease	Y ___	N ____
Steroid Use	Y ___	N ____

HEMATOLOGIC/ONCOLOGIC

Bleeding Tendency	Y ___	N ____
Easy Bruising	Y ___	N ____
Anemia	Y ___	N ____
Sickle Cell Disease	Y ___	N ____
Blood clots in legs	Y ___	N ____
Blood clots in lungs	Y ___	N ____
Radiation Therapy	Y ___	N ____

URINARY/REPRODUCTIVE

Kidney Disease	Y ___	N ____
Urinary Disease	Y ___	N ____
Dialysis	Y ___	N ____
If female, could you be preg.?	Y ___	N ____

Number of live births_____

Number of pregnancies _____

Do you or have you breast fed? Y___ N____

How long in total? _____

Date of last mammogram _____

Negative or Positive results?

History of breast cancer? Y ____ N____

If yes, Personal or Familial?

If yes, Maternal or Paternal?

If yes, whom? _____

RESPIRATORY

Abnormal Chest X-ray	Y ___	N ____
Asthma	Y ___	N ____
Bronchitis	Y ___	N ____
Emphysema	Y ___	N ____
Recent Chest Infection	Y ___	N ____
Shortness of Breath	Y ___	N ____
Shortness of Breath at night	Y ___	N ____
Shortness of Breath on exertion	Y ___	N ____
Cough	Y ___	N ____
Cough with Sputum	Y ___	N ____
Sleep Apnea	Y ___	N ____
Use of C-PAP Machine	Y ___	N ____

MUSCULOSKELETAL

Sciatica	Y ___	N ____
Herniated disc	Y ___	N ____
Arthritis	Y ___	N ____
Rheumatoid	Y ___	N ____
Neck, Back, Arm, Leg Prob.	Y ___	N ____

INFECTIOUS GASTROINTESTINAL

Heartburn	Y ___	N ____
Jaundice	Y ___	N ____
Hepatitis	Y ___	N ____
Ulcers	Y ___	N ____
Hiatal Hernia	Y ___	N ____

SKIN

Staph Infection	Y ___	N ____
Basal cell skin cancer	Y ___	N ____
Melanoma	Y ___	N ____

EYES

Cataracts	Y ___	N ____
Glaucoma	Y ___	N ____

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

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how your personal medical information may be used as well as disclosed and how you can receive access to this information. Please review the following carefully.

This notice of Privacy Practices describes how we may use as well as 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 demographics, that may identify you and that relates to your past, present or future physical and/or mental health condition as well as related health services.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by our physician, office staff and others outside of the office that are involved in your personal care/treatment for the purpose of providing quality 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 PHI to provide, coordinate, and manage your health care as well as any related services. This includes the coordination/management of your health care with a third party. For example, we would disclose your PHI as necessary to a home health agency that provides care to you. Your PHI may be provided to any physician to whom you have been referred to in order to ensure that the physician has any and all necessary information to diagnose and treat you accordingly.

Payment: Your PHI will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require your relevant PHI be disclosed to the provider to obtain approval for hospital admission.

Healthcare Operations: We may use/disclose your PHI as needed in order to support 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 PHI 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 PHI, as necessary, to contact you in order to remind you of appointments.

We may use/disclose your PHI in the following situations without your authorization. These situations include: anything Required By Law, Public Health 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 physicians' practice has taken an action in reliance on the use or disclosure indicated in this authorization.
Your rights: Following is a statement of your rights with respect to your PHI.
You have the right to request a restriction of your PHI: 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 administration actions or proceedings, and PHI that is subject to law that prohibits access to PHI.
You have the right to request a restriction of your PHI: This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment and/or healthcare operations. You may also request that any part of your PHI 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 to whom you want the restrictions 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 disclosure of your PHI, your PHI 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 your 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 PHI. 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 Name 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. Terry Dubrow wants to clarify his practice policy on all refunds. As you have been made aware, the science and art of plastic surgery involves significant risks of complications. These complications, including scarring, poor healing, infection, etc. (described to you in detail on the consent forms), occasionally can, and do, result in a poor outcome and in fact are often responsible for you possibly looking WORSE from your surgical procedure rather than better. Although Dr. Terry Dubrow has significant experience in plastic surgery, he cannot, and does not in any way guarantee that your procedure will not 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 any complications 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.

Signature: _____ Date: _____

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

Warning Regarding HIPAA and Email/Text Communications

Dr. Terry Dubrow and his practice takes every step possible to maintain your privacy and to stay compliant with all HIPAA 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 HIPAA privacy laws and it is possible that some of it could be inadvertently exposed. For this reason we want to make clear that HIPAA 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.

Signature: _____ Date: _____

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

Out-of-Town Patient Memorandum

Dr. Terry Dubrow and his staff appreciates that you have travelled from out of town to seek potential surgical services provided by Dr. Terry 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, including infection, bleeding, scarring and many others often occur significantly after you have already returned home. Because it is impossible to practice effective patient care from a distance, you may require further care in your home town. Although Dr. Terry 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.

Signature: _____ Date: _____

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

NO SHOW/CANCELLATION POLICY

Due to high demand of service, all appointment no shows as well as same day cancellations scheduled for any of the following providers require a $100 service fee that will be charged: Dawn Hawley, Chona Moore, R.N. and Jacqueline Brambila, PA-C. All cancellations must be done 48 hours (two business days) prior to the scheduled appointment time in order to avoid this fee. We understand that health issues may arise, if this is to happen, we require that you provide us with a Doctors/Hospitalization note as to exactly what is occurring. By signing this document, you have acknowledged that you understand the service fee for No Show/Same Day Cancellations and have authorized the specific credit card to charge in the event of this situation.

Thank you for your understanding and cooperation.

Sincerely the office of,
Terry Dubrow M.D., F.A.C.S.
Jacqueline Brambila, PA-C
Chona Moore, R.N.
Dawn Hawley, Medical Esthetician

Credit Card Type: ____ Visa ____ MasterCard ____ Discover ____ Amex

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: Last 3 digits located on the back of the card (CCV):_____

_____ _____
Patient Signature Date

_____ _____
Staff Signature Date