



Date: _____ TERRY J. DUBROW, M.D., F.A.C.S.

Name: _____
First Middle Last

Address: _____
Street City State Zip

Telephone: () _____ () _____
Primary Secondary

May we leave a message on your phone(s)? Primary Secondary

Email: _____ Referred By: _____

Date of Birth: _____ Age: _____ Sex: Male Female

Height: _____ Weight: _____ **For Breast Procedures** – Current bra size: _____ Current implant size: _____
 Saline Silicone

Marital Status: Single Married Divorced Widowed

Occupation: _____

With whom may we share your medical information? _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Telephone: () _____

If someone other than the patient is financially responsible please fill out the next section

Responsible Party Name: _____ Relationship: _____
First Last

Address: _____
Street City State Zip

Telephone: () _____ () _____
Primary Secondary

Employer: _____

Address: _____
Street City State Zip

Social Security Number: _____

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

Signature: Patient / Responsible Party

Date

Please select ALL that apply. If none, select N/A.

What brings you to our office?

- | | | |
|---|--|--|
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Facelift | <input type="checkbox"/> Thigh Lift |
| <input type="checkbox"/> Removal & Replacement of Breast Implants | <input type="checkbox"/> Eyelid Surgery
<input type="checkbox"/> Upper <input type="checkbox"/> Lower | <input type="checkbox"/> Full Body Lift |
| <input type="checkbox"/> Breast Lift | <input type="checkbox"/> Rhinoplasty | <input type="checkbox"/> Brazilian Butt Lift |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Arm Lift | <input type="checkbox"/> Buttock Implants |
| <input type="checkbox"/> Tummy Tuck | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Gynecomastia Repair |
| <input type="checkbox"/> Liposuction- <i>to what area:</i> | | <input type="checkbox"/> Other: _____ |

Personal Health History: Do you or have you had any medical conditions?

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Chest Pain (Angina) | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Psychiatric Diagnosis
(depression, anxiety, etc.) | <input type="checkbox"/> Other: _____ |
| | | <input type="checkbox"/> N/A |

Family History: Do you have a family history of any medical conditions? If yes, please indicate maternal or paternal for each.

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Psychiatric Diagnosis
(depression, anxiety, etc.) | <input type="checkbox"/> Other: _____ |
| | | <input type="checkbox"/> N/A |

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

If yes, please explain _____

Please list & **date all prior operations**, including non-cosmetic procedures.

- | <u>OPERATION</u> | <u>DATE</u> |
|------------------|-------------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

I have not had any prior operations.

Please list & date **all prior hospitalizations.**

HOSPITALIZATION

DATE

1. _____
2. _____
3. _____
4. _____

5. _____
6. _____
7. _____
8. _____

I have not been hospitalized.

Please list **all medications & dietary supplements**, including prescriptions, over the counter medications, Aspirin, vitamins, herbal supplements – Fish oil, Saw palmetto, Flax seed oil, St. John’s Wort, etc.

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

6. _____
7. _____
8. _____
9. _____
10. _____

I do not take any medications or dietary supplements.

Please list **all allergies & reactions** (i.e. Shellfish - Anaphylactic shock, Latex – Rash, Penicillin – Itching).

1. _____
2. _____
3. _____
4. _____

5. _____
6. _____
7. _____
8. _____

I do not have any allergies that I am aware of.

Social History: Please select all that apply.

Drugs - Do you or have you used any of the following:

Tobacco products Yes, for how long? _____ how many packs/day? _____ No

If you are a former smoker, what year did you stop? _____

Vape or Electronic cigarette Yes, for how long? _____ No. If you stopped, when _____

Nicotine gum/patch or any type of smoking aid Yes, for how long? _____ No

If yes, please list products used: _____

Marijuana Yes, for how long? _____ How much? _____ No

Illicit drugs Yes, for how long? _____ No

If yes, which drug(s)? _____

Alcohol Consumption

- Never, I do not drink alcohol
- Rare, 1-2 drinks a week
- Moderate, 7-10 drinks a week
- Heavy, daily or 10+ drinks a week

Did you ever drink heavily in the past? Yes, for how long? _____ No

Diet & Physical Exercise

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

Do you exercise? Yes, how many days/week? _____ Minutes/session? _____ No

Have you experienced a significant **weight loss**?

Yes, how much? _____ Over how much time? _____ No

Have you experienced a significant **weight gain**?

Yes, how much? _____ Over how much time? _____ No

Mental Health: Please select all that apply.

Have you ever been clinically diagnosed with a mental illness?

Yes, please list: _____ No

Have you been clinically diagnosed with depression? Yes No

Do you or have you experienced intense emotions such as anxiety/panic attacks, isolation, loneliness, shame, worthlessness, or emotional withdrawal?

Yes, please list: _____ No

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

Do you feel hopeless about the present future? Yes No

Do you currently have thoughts of harming yourself or others? Yes No

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

Systems Review: Please select all that apply

Do you have (or have you ever had) any of the following conditions/illnesses/symptoms:

Cardiovascular

- Heart bypass surgery Yes No
- Pacemaker Yes No
- Irregular Heartbeat Yes No
- Heart Murmur Yes No
- High Blood Pressure Yes No
- Heart Attack Yes No
- Chest pain/Angina Yes No
- Heart Failure Yes No

Respiratory

- Abnormal Chest X-ray Yes No
- Bronchitis Yes No
- Recent Chest Infection Yes No
- Shortness of Breath Yes No
 - At night On Exertion
- Asthma Yes No
- Emphysema Yes No
- Sleep Apnea Yes No
- Cough Yes No
- Cough with sputum Yes No
- Use of C-PAP machine Yes No

Neurological

Fainting Yes No
Dizziness Yes No
Headache/Migraine Yes No
Double vision Yes No
Stroke Yes No
Seizures Yes No

Endocrine

Steroid Use Yes No
Diabetes Yes No
Thyroid Disease Yes No

Hematology/ Oncology

Bleeding tendency Yes No
Easy bruising Yes No
Anemia Yes No
Sickle Cell Disease Yes No
Blood Clots Yes No
If yes, Legs Lungs
Radiation Therapy Yes No

Infectious Gastrointestinal

Heartburn Yes No
Jaundice Yes No
Ulcers Yes No
Hiatal hernia Yes No
Hepatitis Yes No

Reproductive

History of breast cancer Yes No
If yes, familial personal
If yes, maternal paternal
If yes, whom? _____

Women:

Are you/could you be pregnant Yes No
Number of live births _____
 Vaginal C-section
Number of pregnancies _____
Have you breast fed Yes No
If yes, for how long?
Date of last mammogram _____
Results: + or -

Psychiatric

Obsessive-Compulsive Disorder Yes No
Depression Yes No
Anxiety Yes No
Psychiatric Care Yes No
Emotional Support Animal Yes No

Musculoskeletal

Sciatica Yes No
Herniated disc Yes No
Arthritis Yes No
Rheumatoid Yes No
Neck, back, arm, leg problems Yes No

Urinary

Urinary Disease Yes No
Kidney Disease Yes No
If yes, are you on dialysis Yes No

Skin

Staph infection Yes No
Basal Cell skin cancer Yes No
Melanoma Yes No

Eyes

Cataracts Yes No
Glaucoma Yes No

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 health 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 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.



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

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 your 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 an administrative 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 your 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 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 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 Signature

Date

(Staff) Witness Name/Signature

Date

This Notice was published and becomes effective on/or before April 14, 200



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

Warning Regarding HIPAA and Email/Text Communications

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

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.

Signature: _____ Date: _____



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

Out-of-Town Patient Memorandum

Dr. Dubrow and his staff appreciate 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.

Signature: _____ Date: _____



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

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: Terry Dubrow, M.D., Dawn Hawley, Chona Moore, R.N., and Jacqueline Brambila, PA-C. All cancellations must be done 72 hours (three 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



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

Credit Card Consent Form Disclosure of Patient Health Information

I, _____ authorize Terry Dubrow, M.D., F.A.C.S., and/or Rox Surgery Center, to disclose to my credit card company the health information for the purpose of the release of my health information in the event of a dispute regarding my financial obligations for services rendered by the medical office and/or surgery center.

I understand the receiving party may not further disclose this health information without obtaining a new written authorization from me. I understand this authorization may be canceled or modified at any time upon provision of a written notice to the practices referred to hereinabove. I understand that I may refuse to sign this authorization and my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I understand that I may have a copy of this authorization.

The health information to be used or disclosed is limited to the following: (you may note dates, procedures or use other description).

This authorization is valid until (enter date): _____

Signature: _____ Date: _____

Patient Name: _____

Signed by: ___ Patient ___ Parent/Legal Guardian

___ Personal representative of patient – describe the legal authority that permits the representation: _____