TJD MD

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

Date: _____

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: _____ ' _____ **For Breast Procedures** – Current bra size: _____ Current implant size: _____ cc

Weight: _____ lbs

☐ Saline ☐ Silicone
☐ Textured Implants ☐ Smooth Implants
☐ Under the Muscle ☐ Over the Muscle

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____

With whom may we share your medical information? _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Telephone: ( ) _____

Primary Care Information: Please include the contact information for your Primary Care Provider.

Primary Care Provider: _____

Address: _____
Street City State Zip

Contact Information: ( ) _____ ( ) _____
Phone Number Fax Number

Date of last Physical Exam: _____

Additional Medical Providers: Do you regularly see a Specialist or another Medical Provider (i.e., Cardiologist, Psychiatrist, Dermatologist, Oncologist, etc.)? If so, please list the provider, their specialty and contact information below.

Medical Provider: _____ ( ) _____
Provider Name Specialty Phone Number

Medical Provider: _____ ( ) _____
Provider Name Specialty Phone Number

Medical Provider: _____ ( ) _____
Provider Name Specialty Phone Number

Medical Provider: _____ ( ) _____
Provider Name Specialty Phone Number

1617 Westcliff Drive, Suite 207 Newport Beach, CA 92660
Telephone: (949) 515 – 4111 Fax: (949) 515 – 0318

Please select ALL that apply.

What brings you to our office?

- ☐ Breast Augmentation
- ☐ Replacement of Breast Implants
- ☐ Removal of Breast Implants
- ☐ Breast Lift
- ☐ Breast Reduction
- ☐ Tummy Tuck
- ☐ Liposuction – *what area(s):* _____
- ☐ Facelift
- ☐ Brow Lift
- ☐ Eyelid Surgery ☐ Upper ☐ Lower
- ☐ Rhinoplasty
- ☐ Arm Lift
- ☐ Scar Revision – *what area(s):* _____
- ☐ Hernia Repair
- ☐ Thigh Lift ☐ Inner Thigh ☐ Outer Thigh
- ☐ Buttock Lift
- ☐ Buttock Implants
- ☐ Gynecomastia Repair (*for men*)
- ☐ Other: _____

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

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Attacks
- ☐ Chest Pain (Angina)
- ☐ Seizures
- ☐ Cancer
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease
- ☐ Stomach Problems
- ☐ Gastric Reflux
- ☐ Psychiatric Diagnosis (depression, anxiety, etc.)
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Bleeding Problems
- ☐ Other: _____
- ☐ **No Conditions I am aware of.**

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

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Attacks
- ☐ Chest Pain (Angina)
- ☐ Seizures
- ☐ Cancer
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease
- ☐ Stomach Problems
- ☐ Gastric Reflux
- ☐ Psychiatric Diagnosis (depression, anxiety, etc.)
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Bleeding Problems
- ☐ Other: _____
- ☐ **No Conditions I am aware of.**

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

If yes, please explain: _____

COVID-19 History:

Have you ever received a positive COVID-19 test result? ☐ Yes ☐ No

If yes, please list when: _____

Following the positive result, when did you receive a negative COVID-19 result? _____

Have you received the COVID-19 Vaccine? ☐ Yes ☐ No

If yes, when did you receive your 1st Dose? _____

When did you receive your 2nd Dose? _____

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

OPERATION **DATE**

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

☐ I have not had any prior operations.

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

HOSPITALIZATION **DATE**

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

☐ I have not been hospitalized.

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

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

☐ I do no have any allergies that I am aware of.

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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: _____
Cannabis ☐ Yes, for how long?_____ How much?_____ ☐ No
If yes, what method(s) of consumption? _____
If you are a former cannabis consumer, what year did you stop? _____
Illicit drugs ☐ Yes, for how long?_____ How much?_____ ☐ No
If yes, which drug(s)? _____
If you are a former illicit drug user, what year did you stop? _____

Alcohol Consumption

☐ Never, I do not drink alcohol ☐ Moderate, 7-10 drinks a week
☐ Rare, 1-2 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

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Systems Review: Please select "Yes" for all that apply & "No" for those that do not 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

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
If yes, ☐ Anabolic Steroids
☐ Other: _____

Diabetes	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Immunosuppressant drugs	☐ Yes	☐ No
Hormone Replacement Therapy	☐ 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

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

Respiratory

Abnormal Chest X-ray	☐ Yes	☐ No
Acute Bronchitis	☐ Yes	☐ No
Recent Chest Infection	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No

☐ At night ☐ On Exertion

Asthma	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Sleep Apnea*	☐ Yes	☐ No

**(not to be mistaken with Insomnia)*

Cough	☐ Yes	☐ No
Cough with sputum	☐ Yes	☐ No
Use of C-PAP machine	☐ Yes	☐ No

Psychiatric (*Medically Diagnosed*)

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

Musculoskeletal

Fibromyalgia	☐ Yes	☐ No
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

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

Eyes

Cataracts	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

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Systems Review: (*Continued*) Please select all that apply.
Do you have (or have you ever had) any of the following conditions/illnesses/symptoms:

Reproductive

History of breast cancer ☐ Yes ☐ No
If yes, ☐ familial ☐ personal
If personal, ☐ Left Breast ☐ Right Breast
Treatment: ☐ Radiation, for how long?_____
☐ Chemotherapy, for how long? _____
If yes, ☐ maternal ☐ paternal
If yes, whom? _____

Women:

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

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

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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.

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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 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 Signature Date

_____ _____

(Staff) Witness Name/Signature Date

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

TJD MD

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: _____

TJD MD

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

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.

Signature: _____ Date: _____

TJD MD

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):_____

☐ Please use the card on file from scheduling my consultation appointment

_____ _____
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: _____