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: _____ Height: _____ Weight _____ Sex: ☐ Male ☐ Female

Occupation: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

With whom may we share your medical information? _____

Emergency Contact Information:

Name: _____ Relationship: _____

Telephone: (_____) _____

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.

☐ **I do not take any medications or dietary supplements.**

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

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

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

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

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

What brings you to our office? **Please select ALL that apply.**

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

For Breast Procedures and Breast Reconstruction:

Current bra size _____ Current implant size_____cc

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

Have you/do you experience pain or discomfort related to your breast (neck/back/shoulder)? ☐ Yes ☐ No

If Yes, where _____

Does it affect exercise and daily activities? ☐ Yes ☐ No

Is arm range of motion limited? ☐ Yes ☐ No

Have you/do you take any medication(s) for pain/discomfort? ☐ Yes ☐ No

If Yes, list names of medication(s): _____

How often do you take medication(s) for pain? _____

Do you see a chiropractor for breast, neck, or shoulder pain/discomfort? ☐ Yes ☐ No

If Yes, list provider(s):_____

Do you see a physical therapist for breast, neck, or shoulder pain/discomfort? ☐ Yes ☐ No

If Yes, list providers(s):_____

Do you see an acupuncturist for breast, neck, or shoulder pain/discomfort? ☐ Yes ☐ No

If Yes, list provider(s):_____

Do you have BRCA gene? ☐ Yes ☐ No

Do you have shoulder grooves due to bra straps? ☐ Yes ☐ No

Do you get rashes under your breast? ☐ Yes ☐ No

If Yes, do you use anything to treat the rash ☐ Yes ☐ No

If Yes, list treatment method(s):_____

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

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

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

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

Do you have a personal or family history of anesthetic complications? ☐ Yes ☐ No
If yes, please explain: _____

COVID-19 History:
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? _____
Have you received your booster? _____

Please list & **date all prior operations**, including non-cosmetic procedures.
☐ **I have not had any prior operations**

OPERATION	**DATE**		**DATE**
1. _____		5._____	
2._____		6. _____	
3. _____		7._____	
4. _____		8. _____	

Please list & date **all prior hospitalizations.**
☐ **I have not been hospitalized.**

HOSPITALIZATION	**DATE**		**DATE**
1. _____		5._____	
2._____		6. _____	
3. _____		7._____	
4. _____		8. _____	

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: _____

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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 below.
☐ I do not see any other Specialist(s)

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

Please list the information for your Preferred Pharmacy

Preferred Pharmacy: _____ Telephone: (____) _____

Address: _____
Street City State Zip

Social History: Please select all that apply.

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

Tobacco products ☐ Yes ☐ No
If Yes, for how long? _____, how many packs/day? _____
If you are a former smoker, what year did you stop? _____
Vape or Electronic cigarette ☐ Yes ☐ No
If Yes, for how long? _____
If you are a former vape or electronic cigarette smoker, what year did you stop? _____
Nicotine gum/patch or any type of smoking aid ☐ Yes ☐ No
If Yes, for how long? _____, list products used: _____
Cannabis ☐ Yes ☐ No
If Yes, for how long? _____ Method(s) of consumption: _____
If you are a former cannabis consumer, what year did you stop? _____
Illicit drugs ☐ Yes ☐ No
If Yes, for how long? _____ which drug(s)? _____
If you are a former illicit drug user, what year did you stop? _____

Alcohol Consumption: How often do you consume alcohol?

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

☐ 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

Diet & Physical Exercise

How would you rate your eating habits? ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Do you exercise? ☐ Yes ☐ No
If Yes, how many days/week? _____ How many minutes/session? _____
Have you experienced a significant **weight loss**? ☐ Yes ☐ No
If Yes, how much weight loss? _____ Over how much time? _____
Have you experienced a significant **weight gain**? ☐ Yes ☐ No
If Yes, how much weight gain? _____ Over how much time? _____

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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?_____
☐ Other: _____
If familial, ☐ maternal ☐ paternal

Women:
Are you/could you currently 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: ☐ Abnormal or ☐ Normal

Mental Health: Please select all that apply.
Have you ever been clinically diagnosed with a mental illness? ☐ Yes ☐ No
If Yes, please list: _____
Have you been clinically diagnosed with depression? ☐ Yes ☐ No
Do you or have you experienced anxiety/panic attacks, isolation, loneliness, shame, worthlessness, or emotional withdrawal? ☐ Yes ☐ No
If Yes, please list: _____
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

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

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

_____ _____
Signature: 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 physician's 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.

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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 an 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 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 Signature Date

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

Warning Regarding HIPAA and Email/Text Communications

Dr. Dubrow and his practice take every step possible to maintain your privacy and to stay compliant with all HIPAA laws. However, in current 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 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.

Patient Signature: _____ Date:_____

TJD MD

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

Refund Policy

The science and art of plastic surgery involves significant risks of complications, such as scarring, delayed healing, infection, bleeding, etc. (described in further detail on surgical consent forms). These complications occasionally can and do result in poor outcome(s) and contribute to dissatisfaction of surgical results. Although Dr. Dubrow has significant experience in plastic surgery he cannot guarantee procedures will result in a better outcome than before surgery. Due to significant risks of complications, NO REFUNDS will be processed if surgical procedure(s) result in an unsatisfactory outcome. Furthermore, patients are responsible for additional charges for correction of poor surgical outcome(s).

Your signature below memorializes your understanding of our refund policy.

Patient Signature: _____ Date: _____

TJD MD

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 situation(s) that may arise from treating patients from out of town that may not initially be obvious.

As you may or may not be aware, plastic surgery involves procedures that carry substantial risks of complications that may require additional medical care. Complications such as infection, bleeding, scarring and other concerns often occur after you have returned home. It is not possible to practice adequate patient care from a distance and you may require further care in your hometown.

Should a complication or difficulty arise post-operatively, you will need to immediately seek your own medical care in your local area. Dr. Dubrow's practice will not be able to provide medical services from a distance or over the phone. Please understand that any expenses incurred due to further treatment needs/post-surgical care are patient responsibility.

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

Patient 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 and Same Day Cancellations, scheduled with Terry Dubrow, M.D and Jacqueline Brambila, PA-C, will be charged a fee of $100. All cancellations must be done 72 hours (three business days) prior to the scheduled appointment time to avoid this fee. We understand that health issues may arise, if this is to happen, we require that you provide a Doctors/Hospitalization note.

By signing this document, you have acknowledged that you understand the service fee for No Show/Same Day Cancellations and authorize the credit card below or the card on file to be charged. Thank you for your understanding and cooperation.

Sincerely the office of,
Terry Dubrow M.D., F.A.C.S.
Jacqueline Brambila, PA-C

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

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 Authorization Form

Name of Patient: _____

Name of Cardholder: _____

Billing Address: _____
Street City Zip Code State

Credit Card Type: _____Visa _____ Mastercard ____ Discover ____ Amex

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: Located on the back of the card (CCV):_____

Amount Charged: $365.00 Consultation fee

I authorize Terry Dubrow M.D., A Medical Corporation to charge the agreed amount listed above to the credit card number provided herein. I agree that I will pay for this purchase in accordance with issuing bank cardholder agreement.

By signing and providing my information I understand if I do not cancel my consultation appointment within 72 business hours my consultation fee will be non- refundable.

Cardholder – Please sign and date below

_____ _____
Signature Date

Please email back or fax New Patient Intake Paperwork

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