SUGAR LAND

PLASTIC & RECONSTRUCTIVE SURGERY, COSMETIC SURGERY

PATIENT INFORMATION FORM

Patient Name: ______________________________ Today's Date: ______________

Address: ______________________ City: ______________ State: _____ Zip: ______

Home Phone: __________ Cell Phone: ___________ Email: ______________________

Date of Birth: ______________ Age: ______________ Gender: ______________

Social Security Number: _______________ Marital Status: ______________________

Employer Name: ____________________ Address: _____________________________

Occupation: ______________________________ Work Phone: _________________

Who is your primary care physician? ____

How did you hear about our clinic?

- ☐ Focus Magazine
- ☐ Vietnamese Magazine
- ☐ Web Search Engine
- ☐ Other: ____
- ☐ Patient Referral: __________
- ☐ Friend: ______________
- ☐ Dr. Referral: ___________
- ☐ Health & Fitness Magazine
- ☐ LoveYourLook.com
- ☐ Houston Press

What is the nature of your visit? ____

Emergency Contact

Name: ____________________ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: ________

Home Phone: ______________ Cell Phone: _______________ Work Phone: _____________

Release Results

If it's ok to leave a message with another person, please list them:

Name	Relationship	Comments

Assignment and Release

I, ______________________________ (print name), have insurance coverage and assign directly to Dr. Nguyen all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____ ______________________

Signature of Insured / Guardian Date

Procedures of Interest

Body:

- ☐ Liposuction
- ☐ Tummy tuck
- ☐ Buttock lift
- ☐ Thigh lift
- ☐ Buttock enlargement (Brazilian Butt Lift)
- ☐ Correction of tummy tuck or liposuction
- ☐ Arm lift
- ☐ Body lift
- ☐ Hernia repair
- ☐ Labia repair
- ☐ Other:

Breast:

- ☐ Breast enlargement
- ☐ Breast implant revision
- ☐ Breast reduction
- ☐ Breast lift
- ☐ Breast lift with enlargement
- ☐ Nipple reduction
- ☐ Correction of inverted nipples
- ☐ Male chest reduction

Face:

- ☐ Nose surgery
- ☐ Breathing problems
- ☐ Eyelid lift
- ☐ Brow lift
- ☐ Face lift
- ☐ Ear pinning
- ☐ Neck lift or liposuction
- ☐ Chin enlargement
- ☐ Buccal fat removal

In Office:

- ☐ Botox
- ☐ Juvederm
- ☐ Latisse
- ☐ Skin care
- ☐ Scar revision
- ☐ Mole removal
- ☐ Radiesse
- ☐ Lip augmentation

Skin Transformation

☐ **GloMinerals –** a mineral make-up formulated using powerful pharmaceutical-grade antioxidants, natural, high pigment minerals and broad spectrum UV protection. These products are designed to deliver a flawless complexion while improving the health and appearance of the skin and protecting it from the outside - in.

☐ **Dermesse**- (Sun Damage, Wrinkles, Tightening)- This Skin Health System helps build a strong, healthier skin barrier from the inside-out. By enhancing the skin barrier's function, overall skin tone and texture improve and the appearance of sun damage, hyperpigmentation and brown spots are reduced, if not eliminated.

☐ **Latisse® -** Available by Rx only. A solution applied once daily to your upper lash-line. This makes lashes, longer, thicker and darker.

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

   Surgery Type: Year: ______________________________

   Surgery Type: Year: ______________________________

   Surgery Type: Year: ______________________________

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

   ____

   ____

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Height: ______________ Weight: ______________

	Have you or do you still have:	No	Yes	Description
2.	Asthma	☐	☐	
3.	Emphysema	☐	☐	
4.	High Blood Pressure	☐	☐	
5.	Heart Trouble	☐	☐	
6.	Hepatitis or Liver Trouble	☐	☐	
7.	Kidney Trouble	☐	☐	
8.	Diabetes	☐	☐	
9.	Epilepsy or Seizures	☐	☐	
10.	Stroke	☐	☐	
11.	Problem Scarring	☐	☐	
12.	Have you been advised to or had psychiatric care?	☐	☐	

13. Others Not Listed: ______________________________

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? ______________
2. Do you drink? ☐ No ☐ Yes, how much? ______________
3. Do you have children? ☐ No ☐ Yes, how many? ______________

Section IV: Medications

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

____

____

Section V: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

____

____

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: ______________________________ Date: ______________

SUGAR LAND

PLASTIC & RECONSTRUCTIVE SURGERY, COSMETIC SURGERY

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a “friendly” version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the
patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ______________________ (print name), do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: ____ Date: ________________________

Sugar Land Plastic Surgery

John T. Nguyen, MD

www.drjohnnguyen.com

PATIENT REGISTRATION

Patient Name: ______________________________ **Birth Date:** __________ **Age:** ______
(please print) (last) (first) (middle)

Mailing Address: ____

City: __________________ **State:** _____ **Zip:** ________ **Social Security Number:** ____________

MARITAL STATUS (please circle): Single Married Divorced Widowed **SEX (please circle): Male Female**

I may be reached at the following number(s), and will contact you if I wish to be removed from the contact list (check preferred):

☐ **Home Number:** ____________ ☐ **Work Number:** ____________ ☐ **Cell Number:** ____________

Best Time To Call: ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Other:** ______________________

E-mail: ______________________________ **Fax Number:** ______________

Employer: ______________________ **Occupation:** ______________________

Person Responsible for Billing: ______________________________________

In case of emergency, who should we notify?

Name: ______________________ **Relationship:** ______________________

☐ **Home Number:** ____________ ☐ **Work Number:** ____________ ☐ **Cell Number:** ____________

HOW DID YOU HEAR ABOUT OUR CLINIC?

☐ **Focus Magazine** ☐ **Patient Referral** ______ ☐ **Health & Fitness Magazine** ☐ **Mailing**
☐ **Vietnamese Magazine** ☐ **Friend** __________ ☐ **LoveYourLook.com** ☐ **Other:** ________
☐ **Dr. Referral** ________ ☐ **Web Search Engine** ☐ **Weddings in Houston**

Cosmetic consultations are complimentary. There is a $200 charge for second opinions and non-cosmetic surgery consultations, such as reconstruction due to an accident, scars, etc. Payment is due at the time of consultation. When a procedure is scheduled, a $500 deposit is required. This deposit is non-refundable unless the procedure is cancelled 7 business days prior to the scheduled procedure. Full payment is required at the time of the pre-op appointment or within 15 days prior to surgery. Deposits for non-surgical procedures, such as laser, are non-refundable unless the procedure is cancelled 48 hours prior to the scheduled date. It is the patient's responsibility to provide an appropriately trained translator if necessary.

SIGNATURE: ______________________________ **DATE:** ______________

Sugar Land Plastic Surgery

John T. Nguyen, MD

www.drjohnnguyen.com

Please let us know your concerns and interests so that we may best serve you.

- ☐ Facelift
- ☐ Laser Resurfacing
- ☐ Breast Augmentation
- ☐ Botox®
- ☐ Forehead or Brow Lift
- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Eyelid Procedures
- ☐ Injectible Fillers (Radiesse®, Juvederm®)
- ☐ Rhinoplasty
- ☐ Scar Revision
- ☐ Breast Reduction/Lift
- ☐ Laser Hair Removal
- ☐ Chin Enhancement
- ☐ Vein Removal
- ☐ Liposuction
- ☐ Hair Restoration
- ☐ Other: ____

____

____

SKIN TRANSFORMATION

Please let us know if you would like information regarding the following services and procedures:

Exclusive Skin Care Products:

☐ GloMinerals – a mineral make-up formulated using powerful pharmaceutical-grade antioxidants, natural, high pigment minerals and broad spectrum UV protection. These products are designed to deliver a flawless complexion while improving the health and appearance of the skin and protecting it from the outside - in.

☐ Nia 24 (Sun Damage, Wrinkles, Tightening)- The Pro-Niacin molecule, found in each of the NIA 24 products, helps build a strong, healthier skin barrier from the inside-out. By enhancing the skin barrier's function, overall skin tone and texture improve and the appearance of sun damage, hyperpigmentation and brown spots are reduced.

☐ **Chemical Peels** for sun damage, wrinkles and acne scars

Sugar Land Plastic Surgery

John T. Nguyen, MD

www.drjohnnguyen.com

MEDICAL HEALTH HISTORY

Patient Name: ____ ***Birth Date:*** ___________ ***Age:*** ________

Medical History:

☐ Heart Attack	☐ Bleeding Problems	☐ Arthritis	☐ Heart Murmur
☐ Stroke	☐ Anesthesia problems	☐ High blood pressure	☐ Blood Transfusion
☐ Cancer	☐ TB exposure	☐ Asthma/wheezing	☐ Anemia
☐ Diabetes	☐ Seizures	☐ HIV positive/AIDS	☐ Hepatitis: TypeA,B,C
☐ Pacemaker	☐ Shortness of breath	☐ Ulcers/Reflux	☐ Varicose veins, phlebitis

Medical Illnesses (not listed above):

____

Allergies to Medications:

____

Current Medications (Prescriptive or Over-the-counter):

____

____

Injuries/Hospitalizations/Surgeries (Description and Date):

____

____

Smoking: **Daily** **Socially** **None**

Alcohol: **Daily** **Socially** **None**

I hereby testify that the information provided about is accurate and current.

Signature:____

Date:____

OFFICE USE ONLY

PROCEDURE(S) **ESTIMATED OR TIME**

____

____ ____________________

Sugar Land Plastic Surgery

John T. Nguyen, MD

www.drjohnnguyen.com

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Texas. This includes issues relating to your treatment, payment and our health-care operations. Your personal health information will never be given to anyone – even family members – without your written consent. You, of course, may give written authorization to us to disclose your information to third parties.

Our office and electronic systems are secure from unauthorized access and our employees are trained to ensure the confidentiality of your records is protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations and comply with the law. This may include your name, address, telephone number(s), Social Security, employment data, medical history, health records, etc. While most of the information will be obtained from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use your health information to communicate reminders about your appointments including voicemail, answering machines and postcards.

Patient Rights

You have the right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being our patient. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Sugar Land Plastic Surgery

John T. Nguyen, MD

www.drjohnnguyen.com

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Sugar Land Plastic Surgery. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

Sugar Land Plastic Surgery reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

I hereby authorize John T. Nguyen, MD, PA to take pre-and post-operative photographs of me for the purpose of medical record documentation and patient education. Provided that there is no identification attached to the photographs, I (WILL) (WILL NOT) allow these to be used for patient education.

Signature:____ Date: ______________________________

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.
Any member of my immediate family
Spouse Only
Other (Please Specify)

____

Name of Patient or Personal Representative

____

Signature of Patient or Personal Representative

____

Date

____

Description of Personal Representative’s Authority