ANDREW SMITH
MD FACS
PLASTIC AND RECONSTRUCTIVE SURGERY

New Patient Information

Today's Date: _____

Welcome to the office of Andrew Smith, MD, FACS. As a new patient, please fill out the information found below to the best of your ability. Please answer these health and beauty related questions to help us design the ideal experience for you. All information will remain confidential. ***The information provided below and during your scheduling may be used to contact you. Please do not provide information if cannot be used.***

(Patient) Last: _____ **First:** _____**Middle:**_____ _____

SSN: _____ - _____ - _____ **Drivers License Number:** _____**Date of Birth:** ____/____/_____ **Age:** ____

Mailing Address: _____

City: _____ **State/Country:** _____ **Zip Code:** _____

Telephone: Home: _____ **Work:** _____ **Cell:** _____

Primary Email Address: _____

Sex: ☐ Female ☐ Male **Martial Status:** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by: _____ **Occupation:** _____

How did you hear about Andrew Smith, MD, FACS?

☐Real Self ☐Yelp ☐Social Media ☐New Beauty ☐Other/Define: _____ ☐Referred by: _____ ☐Patient

Please check all of Dr. Andrew Smith's surgical and non-surgical procedures that interest you:

FACE:	**BREAST:**	**BODY:**
☐ Facelift, Neck Lift	☐ Breast Augmentation	☐ Tummy Tuck
☐ Eyelid Surgery	☐ Breast Revision/Reconstruction	☐ Surgical Body Contouring (Liposuction)
☐ Prominent Ear/Otoplasty	☐ Breast Lift	☐ Body Lift, Arm Skin Reduction
☐ Other: _____ _____	☐ Breast Reduction	☐ Other: _____
	☐ Nipple Surgery	
	☐ Other: _____	

NON SURGICAL:	**NON SURGICAL (cont.):**
☐ Botox Injections	☐ Permanent Make-Up
☐ Dermal Fillers (e.g. Voluma, Juvederm)	☐ Sun Damage Repair
☐ CoolSculpting	☐ Clear + Brilliant
☐ Peels to Improve Skin Quality/Pigmentation	☐ Eyelash Enhancement
☐ Anti-Aging Prevention Skincare	☐ Other: _____
☐ Kybella	☐ Unsure, Need Consultation

EMERGENCY CONTACT:
Name: _____ **Phone:** _____ **Relationship:** _____

INSURANCE: (INSURANCE PATIENTS ONLY):
Name of Insurance Provider: _____ Primary Insurer: _____
Contact #: _____ Group #: _____ SSN: _____

ASSIGNMENT AND RELEASE (INSURANCE PATIENTS ONLY): I, undersigned, have insurance coverage with the company named above. I assign directly to Dr. Andrew Smith, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, including possible hospitalization, 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 of my insurance submissions.

Patient Signature: _____ Date: _____

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Patient Name: _____

INSURANCE SERVICES:

Andrew D. Smith, M.D., Inc. will submit claims to your insurance company for all medical services rendered that are covered benefits. We will attempt to verify eligibility and benefits with your insurance company; however, this verification is not a guaranty of payment. Any expenses deemed not covered by your insurance company will be your financial responsibility.

All monies owed by the patient, i.e., office visit co-payments, non-covered services, or supplies, are due at the time of service. Also, when applicable, co-insurance percentages and/or deductibles will be collected at the time of service. Please be aware that this office will bill only for the physician's services. Any other services related to your office visits, i.e. laboratory, radiology, or pathology, will be billed by the facility providing these services.

The contract between Andrew D. Smith, M.D., Inc. and your health plan, as well as the contract between you and your health plan requires that you make payment in full of all co-payments and deductible amounts deemed to be your responsibility upon claims processing. Additional discounts are forbidden by contract unless financial hardship is documented and approved by this office.

COSMETIC SURGERY

Patients receiving surgery that is not a covered benefit of your insurance plan must pay for the services in full prior to the surgery. For your convenience, Andrew D Smith, M.D., Inc., has made financial arrangements with the Surgery Center and Anesthesiologist to provide a global package rate. You will not receive a bill from the Surgery Center or the Anesthesiologist. You may receive a bill for pathology, lab, EKG, or respiratory services, if they are required.

During your cosmetic surgery, you may receive a surgical service that is covered by your insurance company. We will bill your insurance company if you receive a covered surgical service. Your doctor will discuss the possible covered services.

PAYMENT

Our office accepts the following form of payments: Visa, MasterCard, American Express, cash and personal checks. **A twenty-dollar ($20) service charge will be assessed to your account for any check returned by your bank.**

_____ _____

Responsible Party Signature: **Date:**

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NOTICE OF PRIVACY PRACTICES

This noticed describes how health information about you, as a patient of Andrew D. Smith, M.D., Inc. may be used and disclosed, your rights as a patient and how you can access your health information. This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPAA).

Our Commitment to Your Privacy:

Andrew D. Smith, M.D., Inc. is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information as prescribed by HIPAA. These HIPAA guidelines are summarized below for your information and understanding.

Use and Disclosure of Your Health Information:

The following circumstances may require Andrew D. Smith, M.D., Inc. to use or disclose your health information.

1. To comply with request from public health authorities and health oversight agencies which are required by law to collect health information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Andrew D. Smith, M.D., Inc. will only make such disclosure to a person or organization able to prevent the threat.
5. If you are a member of U.S. or foreign military forces, including veterans, and if required by the appropriate authorities.
6. To federal government officials for intelligence and national security activities required by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Worker's Compensation and similar programs.

Your Rights Regarding Your Health Information:

1. You can request that Andrew D. Smith, M.D., Inc. communicate with you about your health related issues in a particular manner or at a certain location. Therefore, you may ask to be contacted at home rather that at work, via personal fax or cell telephone for appointment confirmation or related scheduling matters, for results of specific diagnostic test, and such reasonable request will be accommodated.
2. You can request a restriction regarding the use of disclosure of your health information for treatment, payment, or health care operations by Andrew D. Smith, M.D., Inc.
3. You have the right to request that Andrew D. Smith, M.D., Inc. restrict our disclosure to your health information to only certain individuals involved in your care or payment of your care, such as a family member or friend. However, Andrew D. Smith, M.D., Inc. is not required to agree to your request, but if we do agree, Andrew D. Smith, M.D., Inc. is bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.
4. You have the right to inspect and obtain a copy of your health information that may be used to make decisions about you, including patient medical and billing records, with the except of psychotherapy notes. You must submit your request in writing to Andrew D. Smith, M.D., Inc., 18 Endeavor Suite 102, Irvine CA 92618. Obtain a request from the front desk.
5. You may ask Andrew D. Smith, M.D., Inc. to amend your health information if you believe it is incorrect or incomplete as long as the information is kept by or for Andrew D. Smith, M.D., Inc. to request an amendment, make your request in writing with a supporting reason for the amendment to your health information to Andrew D. Smith, M.D., Inc. at 18 Endeavor, Suite 102, Irvine CA 92618. Obtain a request from the front desk.
6. You are entitled to receive a copy of the Notice of Privacy Practices by asking the front desk person to make a copy for you.
7. If you believe your privacy rights have be violated, you may file a complaint with Andrew D Smith, M.D., Inc. or with the Secretary of the Department of Health and Human Resources. Any complaint filed with Andrew D. Smith, M.D., Inc. must be submitted in writing. You will not be penalized for filing a complaint. Obtain the proper form to file a compliant from a person at the front desk.
8. Andrew D. Smith, M.D., Inc. will obtain your written authorized for uses and disclosure that are not identified by this Notice of Privacy Practices or permitted by law.

If you have any questions regarding this Notice of Privacy Practices or Andrew D. Smith, M.D., Inc. health information privacy policies, please contain our staff at Andrew D. Smith, M.D., Inc. 18 Endeavor, Suite 102, Irvine CA 92618

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NOTICE OF PRIVACY PRACTIVIES ACKOWNLEDGEMENT

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES policy from Andrew D. Smith, M.D., Inc. The Notice of Privacy Practices is supplied in accordance with the Privacy Rule that in an integral part of the Health Insurance Portability and Accountability Act (HIPAA)

_____ _____

Signature **Date**

_____

Patient Name

_____

Signor Relationship to Patient

18 Endeavor Suite 102, Irvine, California 92618 Tel: (949) 653-7000 Fax: (949) 453-0553

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MEDICAL QUESTIONNAIRE

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____/_____/_____

Primary Care Physician: _____

Physician Who Referred You (if applicable): _____

Other Physician(s) Caring for You: _____

Is This Visit Due To a Work Related Injury? ☐ Yes ☐ No Date of Injury: _____/_____/_____

Are You Pregnant? ☐ Yes ☐ No

Reason for Today's Visit: _____

****

PAST MEDICAL HISTORY:

SURGERIES AND HOSPITALIZATIONS
List all previous surgeries/hospitalizations and approximate dates:

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

CURRENT MEDICATIONS WITH DOSAGES

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

Do you take any "blood thinners"? ☐ Yes ☐ No
Do you take any medications that contain aspirin? ☐ Yes ☐ No

ALLERGIES TO DRUGS: ☐ Yes ☐ No
1. _____
2. _____
3. _____

ENVIRONMENTAL ALLERGIES (FOOD): ☐ Yes ☐ No
1. _____
2. _____
3. _____

USE THIS SPACE TO PROVIDE ADDITIONAL INFORMATION FROM THIS PAGE:

_____

_____

_____

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PATIENT NAME: _____ **DATE:** _____

HAVE YOU BEEN DIAGNOISED WITH OR TREATED FOR ANY OF THE FOLLOWING DISEASES:

	YES	NO		YES	NO
Angina or Heart Attack			Glaucoma/Cataracts		
Anesthesia Complications			Headaches		
Asthma			High Blood Pressure		
Bladder Disease			Immune Suppression/HIV		
Bleeding Problems			Irregular Heartbeat		
Blood Transfusions			Liver problems/Hepatitis		
Congestive Heart Failure			Sleep Apnea		
Cancer			Snoring		
Diabetes Mellitus			Stroke		
Emphysema			Thyroid Disease		
Epilepsy			Ulcers or Reflux (GERD)		

REVIEW OF SYSTEMS- PAST THIRTY (30) DAYS:
Check any illness problem, or symptom you have had in the past thirty (30) days:

EYES: _____ Change in Vision _____ Pain _____ Blurred or Double Vision _____ Glaucoma	**CONSTITUTIONAL SYMPTOMS:** ____ Fever, Chills, or Night Sweats _____ Recent Weight Change _____ Skin Problems: _____
RESPIRATORY: ____ Cough ____ Spitting up Blood ____ Wheezing	**MUSCULOSKELETAL:** ____ Joint Pain/Stiffness ____ Muscle Pain/Cramps/Weakness ____ Back Pain
GENITOURINARY: ____ Flank Pain ____ Problems with Urination ____ Abnormal Urine Color	**GASTROINTESTINAL** ____ Problems with Bowel Movements ____ Nausea or Vomiting ____ Rectal Bleeding, Blood in Stool, Vomiting Blood ____ Abdominal Pain or Heartburn
EARS/NOSE/THROAT/MOUTH ____ Hearing Loss ____ Trouble Swallowing ____ Sore Throat ____ Sinusitis	**CARDIOVASCULAR** ____ Chest Pain ____ Palpitations ____ Shortness of Breath, Walking or Lying Flat ____ Swelling of Feet , Ankles, or Hands
HEMATOLOGIC/LYMPHATIC ____ Slow to Heal After Cut ____ Bleeding or Bruising Tendency	**NEUROLOGIC/PSYCHOLOGIC** ____ Headaches ____ Numbess or Thinging Sensation ____ Fainting or Loss of Conciousness ____ Depression/Nervousness/Insomnia

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PATIENT NAME: _____ **DATE:** _____

FAMILY HEALTH HISTORY:	**FATHER**		**MOTHER**	
	YES	**NO**	**YES**	**NO**
Alive				
Age or Age at Death				
Diabetes Mellitus				
Congestive Heart Failure				
High Blood Pressure				
Adverse Anesthetic Reactions				
Liver Problems/Hepatitis				
Bleeding Disorders				

HABITS:

	YES	**NO**
Do you now smoke?	_____ Cigars _____ Cigarettes _____ Packs Per Day	
Have you ever smoked?	_____ How Long Ago? _____ How Many Years _____ Packs Per Day _____ Month/ Year you Quit	
Have you ever used chew or snuff?		
Do you drink alcohol?	_____ How many drinks per day (average)? _____ When did you last drink?	
Have you used illicit drugs? (marijuana, heroin, cocaine, LSD, crack)	If yes, please circle which ones.	
Do you exercise on a regular basis?	Type of Exercise _____ How Often: _____	

****

Please use this space to provide additional health information you would like us to know:

_____

_____

_____

_____

The information above is true and correct.

_____ _____

Patient or Person Completing this form/Relationship **Date**

Reviewed by M.D.: _____

18 Endeavor Suite 102, Irvine, California 92618 Tel: (949) 653-7000 Fax: (949) 453-0553