SALMON CREEK PLASTIC SURGERY

COSMETIC
PATIENT REGISTRATION FORM

Name: Last _____ First_____ MI_____

Date of Birth____/_____/_____ Weight_____ Height_____ Sex:☐M ☐F SSN _____

Address _____ City _____State____Zip_____

Cell Phone (_____) _____-_____ Home Phone (_____) _____-_____

Email_____ Preferred Language _____

Emergency Contact: _____ Phone: _____

Race: ☐White ☐American Indian ☐Native Alaskan ☐Asian ☐African American ☐Other

Ethnicity: ☐Hispanic or Latino ☐Caucasian ☐Asian ☐Pacific Islander ☐Non-Hispanic ☐ Other

PRIMARY CARE PHYSICIAN_____ Phone: _____

REFERRING PHYSICIAN _____ Phone:_____

How Did You Hear About Us?☐Drive By ☐Website ☐ Google ☐Yelp☐Social Media ☐Friend/Family

Who can we thank for referring you to us? _____

MEDICATION CONSENT: *In order to ensure that the treatment you receive at Salmon Creek Plastic Surgery does not conflict with any of your existing treatments, we would like to retrieve your prescription history electronically from the surescripts pharmacy clearing house.* ☐ **ACCEPT** ☐ **DECLINE**

X_____ **X**_____
Sign: Date:

Non Surgical Cosmetic Treatment Interest Questionnaire
Please select any treatments in which you have an interest:

Botox: ☐Frown Lines ☐Crow's Feet ☐Forehead Lines ☐Gummy Smile ☐Excessive Sweating *(hyperhidrosis)*

Dermal Fillers: ☐Deep Wrinkles on Face ☐Smile Lines ☐Lip Volume Loss ☐Jowls

Laser: ☐Brown Spots ☐Melasma ☐Spider Veins (Face/Legs) ☐Redness/Rosacea ☐Tattoo Removal
☐Laser Hair Removal ☐Laser Peel/Resurfacing ☐Rejuvenation/Build Collagen/Improve Texture

Fat Reduction: ☐Kybella (chin) ☐TruSculpt (chin/body)

Medical Skin Care: ☐ZO Skin Health ☐ Epionce

Consultation Done with _____ Today's Date: ____/____/_____

Any Special Events Coming Up? ☐ YES ☐ NO Event Date: ____/____/_____

Treatment Plan Recommendations:

Lasers/TruSculpt: _____

Injectables: _____

Skin Care: _____

Instructions: _____

Richard K. Green, MD., FACS | Virginia S. Huang, MD., FACS | Jane Namkung, MD.
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www.salmoncreekps.com

SALMON CREEK
PLASTIC SURGERY

HIPAA
PATIENT PRIVACY

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowlege that I have read and/or received a copy of the Statement of Privacy Practices for the offices of Salmon Creek 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. The Statement of Privacy Practices is also posted in the facility.
Salmon Creek Plastic Surgery reserves the right to change the privacy practices currently 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 the first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. *(I understand that the default answer is "NO." Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)*

SPOUSE ONLY ☐ YES ☐ NO

OR

Any Member of My Immediate Family (i.e. Spouse, Children, Siblings, etc.) ☐ YES ☐ NO

Any Member of My Extended Family (i.e. Parents, Grandchildren) ☐ YES ☐ NO

Other: _____

Name of Patient (please print): _____

Patient's Signature: _____ Date: ____/____/_____

PLEASE FILL OUT IF PATIENT IS A MINOR OR REQUIRES A PERSONAL REPRESENTATIVE:

Patient's Personal Representative (please print):_____ Date: ____/____/_____

Personal Representative's Signature:_____

Representative's Phone Number: _____

FOR OFFICE USE ONLY BELOW THIS LINE

ACKNOWLEDGEMENT NOT OBTAINED

Provided Prior To Treatment?	☐ YES	☐ NO	Date Provided:
Reason For Not Obtaining Patient's Signature.	☐		Needed more time to review statement.
	☐		Wanted to consult another person before signing.
	☐		Physically unable to sign.
	☐		No reason offered.
	☐		Other:

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MEDICAL HISTORY

Constitutional Symptoms
- ☐ Fever or night sweats
- ☐ Unexplained weight loss or gain
- ☐ History of sleep apnea/loud snoring
- ☐ History of a severe reaction to anesthesia

Eyes, Ears, Nose, Mouth, Throat
- ☐ Vision changes (blurry, double, etc.)
- ☐ Vision loss
- ☐ Dry eyes or watery eyes
- ☐ Eyelid drooping
- ☐ History of cold sores
- ☐ Recent dental work
- ☐ Nasal/Sinus congestion
- ☐ History of difficult intubation

Breast
- ☐ Breast pain
- ☐ Breast mass
- ☐ Nipple discharge
- ☐ Nipple retraction

Endocrine
- ☐ Heat or cold intolerance
- ☐ Hair loss

Integumentary
- ☐ Excessive sweating
- ☐ New or changing skin lesion
- ☐ Rash
- ☐ History of keloid scar

Musculoskeletal
- ☐ Hand or wrist pain
- ☐ Joint swelling or stiffness
- ☐ Back pain
- ☐ Joint redness or warmth
- ☐ Crunching of joints
- ☐ Difficulty moving around

Neurological/Psychological
- ☐ Dizziness
- ☐ Headaches or migraines
- ☐ Seizures
- ☐ Weakness/Numbness in arms/legs
- ☐ History of passing out
- ☐ Chronic pain: area _____
- ☐ Anxiety or depression
- ☐ Panic attacks

Hematological & Lymphatic
- ☐ Easy bleeding or bruising
- ☐ History of a bleeding or clotting disorder
- ☐ History of a blood clots in the legs or lungs
- ☐ HIV
- ☐ History of a blood transfusion
- ☐ History of anemia

Cardiovascular & Respiratory
- ☐ Leg swelling
- ☐ Chest pain or pressure
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Difficulty breathing while lying flat
- ☐ Reduced ability to exercise
- ☐ Dry or productive cough
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ History of hepatitis

Genitourinary
- ☐ Kidney stones
- ☐ History of kidney disease

Please complete the backside of this form.

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MEDICAL HISTORY

Have you ever smoked/vaped? ☐ Y ☐ N

If yes: How much? _____ How many years? _____

Have you quit smoking? ☐ Y ☐ N

If so: when ____/____/_____

Do you drink alcoholic beverages? ☐ Y ☐ N

If so: how many per week? _____

Do you take any illicit drugs (marijuana, etc)? ☐ Y ☐ N

If so, what _____

Have you ever had cancer? ☐ Y ☐ N

If so: What kind? _____

Females: Are you currently pregnant? ☐ Y ☐ N

Or lactating recently? ☐ Y ☐ N

Have you had a breast exam? ☐ Y ☐ N Date: ____/____/_____

Have you had a Mammogram? ☐ Y ☐ N Date: ____/____/_____

Please check if you have or have had any of the following:

☐ Heart Attack ☐ Pacemaker ☐ High blood pressure ☐ Sleep Apnea ☐ Asthma ☐ Stroke

Please list any surgeries: _____

Please list any medical problems not listed above (Diabetes, heart problems, etc): _____

_____

List current medications: _____

_____

Allergies_____

Latex? ☐ Y ☐ N Adhesive Tapes? ☐ Y ☐ N

Family History:

Do any of these run in your family? Please indicate relationship (Father, etc)

Bleeding or Clotting Disorders	☐ Y	☐ N	Relationship: _____
Heart Disease	☐ Y	☐ N	Relationship: _____
Blood Clots in Legs or Lungs	☐ Y	☐ N	Relationship: _____
Diabetes	☐ Y	☐ N	Relationship: _____
Vascular Disease	☐ Y	☐ N	Relationship: _____
Stroke	☐ Y	☐ N	Relationship: _____
High Blood Pressure	☐ Y	☐ N	Relationship: _____
Severe reaction to Anesthesia	☐ Y	☐ N	Relationship: _____
History of cancer?	☐ Y	☐ N	Relationship: _____

If yes: what kind?_____

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