SALMON CREEK
PLASTIC SURGERY

# INSURANCE
## 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:

## Patient Financial Agreement

I hereby authorize Salmon Creek Plastic Surgery to furnish insurance carriers with any information concerning my medical care necessary to secure insurance benefits. I also assign medical payments from my insurance to Salmon Creek Plastic Surgery.

I understand that I am personally responsible for all charges by my physician, whether or not paid for by my insurance, and I guarantee payment of the bill in full. I understand that my insurance will be billed as a courtesy to me and that I am ultimately responsible.

_____ _____
Responsible Party Signature: Date:

**Richard K. Green, MD., FACS | Virginia S. Huang, MD., FACS | Jane Namkung, MD.**
**13712 NE 10th Ave, Vancouver, WA 98685 | Office (360) 823-0860 | Fax (360) 828-1407**
**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: |

**Richard K. Green, MD., FACS | Virginia S. Huang, MD., FACS | Jane Namkung, MD.**
**13712 NE 10th Ave, Vancouver, WA 98685 | Office (360) 823-0860 | Fax (360) 828-1407**
**www.salmoncreekps.com**

SALMON CREEK
PLASTIC SURGERY

# 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.***

**Richard K. Green, MD., FACS | Virginia S. Huang, MD., FACS | Jane Namkung, MD.**
**13712 NE 10th Ave, Vancouver, WA 98685 | Office (360) 823-0860 | Fax (360) 828-1407**
**www.salmoncreekps.com**

SALMON CREEK
PLASTIC SURGERY

# 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?_____

**Richard K. Green, MD., FACS | Virginia S. Huang, MD., FACS | Jane Namkung, MD.**
**13712 NE 10th Ave, Vancouver, WA 98685 | Office (360) 823-0860 | Fax (360) 828-1407**
**www.salmoncreekps.com**