



## New Patient Registration

<b>Today's Date:</b>		<b>Social Security Number:</b>	
<b>Name:</b> <i>Last</i>		<i>First</i>	<i>Middle</i>
How do you like to be addressed:		<b>Date of Birth:</b>	
<b>Address:</b> <i>Street</i>			
<i>City</i>		<i>State</i>	<i>Zip</i>
<b>Email Address:</b>			
<b>Preferred Contact Number:</b> <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<i>Cell Phone:</i>	
<i>Home Phone:</i>		<i>Work Phone:</i>	
<b>Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced		<b>Spouse's Name:</b>	
<b>Employment Status:</b> <input type="checkbox"/> Employed <input type="checkbox"/> Home Maker <input type="checkbox"/> Not Employed <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Student			
<b>Employer:</b>			
<i>Street</i>			
<i>City:</i>		<i>State:</i>	<i>Zip:</i>
<i>Company Tel:</i>		<i>Company Fax:</i>	
<b>Primary Care Physician:</b>		<b>Did he refer you?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Specialty:</i> <input type="checkbox"/> Family Practice <input type="checkbox"/> Internist <input type="checkbox"/> Ob/Gyn <input type="checkbox"/> Pediatrics <input type="checkbox"/> Other _____			
<i>Street</i>			
<i>City:</i>		<i>State:</i>	<i>Zip:</i>
<i>Telephone</i>		<i>Fax</i>	

What is the reason for your visit today? \_\_\_\_\_

\_\_\_\_\_

### Insurance Information:

Please provide us with your **insurance card** and **driver's license** so that we may retain a copy for our records. Thank you!

## Medical History Form

How is your general health?  Good  Average  Poor Most recent physical examination? \_\_\_\_\_

### Current Medical Problems:

Anemia	<input type="checkbox"/> Y	<input type="checkbox"/> N	Depression	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hypothyroidism	<input type="checkbox"/> Y	<input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Mitral Valve Prolapse	<input type="checkbox"/> Y	<input type="checkbox"/> N
AIDS/HIV	<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y	<input type="checkbox"/> N
Bleeding Disorder	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stomach Ulcer	<input type="checkbox"/> Y	<input type="checkbox"/> N
Breast Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hyper-thyroidsim	<input type="checkbox"/> Y	<input type="checkbox"/> N			

Other: \_\_\_\_\_

### Previous Surgeries: (Type/Date/Surgeon/Complications or difficulties)

### Previous Plastic Surgeries: (Type/Date/Surgeon/Complications or difficulties)

### Family History of Medical Problems:

Anemia	<input type="checkbox"/> Y	<input type="checkbox"/> N	Depression	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hypothyroidism	<input type="checkbox"/> Y	<input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Mitral Valve Prolapse	<input type="checkbox"/> Y	<input type="checkbox"/> N
AIDS/HIV	<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y	<input type="checkbox"/> N
Bleeding Disorder	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stomach Ulcer	<input type="checkbox"/> Y	<input type="checkbox"/> N
Breast Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hyperthyroidsim	<input type="checkbox"/> Y	<input type="checkbox"/> N			

Other: \_\_\_\_\_

**Do you smoke?**  Yes  No How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

**Do you drink alcoholic beverages?**  Yes  No **If yes:**  Infrequently  Socially  Frequently

**Do you use recreational drugs?**  Yes  No

**Do you have a bleeding disorder or bleed easily?**  Yes  No

**Do you have any Drug Allergies:**  Yes  No If yes, please list medication and reaction to medication:

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**Current Medications (including vitamins, herbal, and non-prescription medications):**

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**Review of Systems:**

Do you have now or have you had within the past year:

No, I do not have any of the symptoms below

<b><u>General/Constitutional:</u></b>		<b><u>Breast:</u></b>		<b><u>Skin:</u></b>	
Fever/Chills	<input type="checkbox"/> Y <input type="checkbox"/> N	Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Rashes	<input type="checkbox"/> Y <input type="checkbox"/> N
Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Nipple discharge	<input type="checkbox"/> Y <input type="checkbox"/> N	Itching	<input type="checkbox"/> Y <input type="checkbox"/> N
Weight loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Lumps & masses	<input type="checkbox"/> Y <input type="checkbox"/> N	Hyper-pigmentation	<input type="checkbox"/> Y <input type="checkbox"/> N
Weight gain	<input type="checkbox"/> Y <input type="checkbox"/> N	Neck & shoulder pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin lesions	<input type="checkbox"/> Y <input type="checkbox"/> N
Poor general health	<input type="checkbox"/> Y <input type="checkbox"/> N	Rashes under breasts	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin lacerations	<input type="checkbox"/> Y <input type="checkbox"/> N
Poor exercise tolerance	<input type="checkbox"/> Y <input type="checkbox"/> N	Shoulder grooving	<input type="checkbox"/> Y <input type="checkbox"/> N	Dry Skin	<input type="checkbox"/> Y <input type="checkbox"/> N
<b><u>Eyes:</u></b>		<b><u>Respiratory:</u></b>		<b><u>Hematologic/Lymphatic/Endocrine:</u></b>	
Double vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Difficulty breathing	<input type="checkbox"/> Y <input type="checkbox"/> N	Sweating problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Blurry vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive hair growth	<input type="checkbox"/> Y <input type="checkbox"/> N
Eye pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Dry cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Hair loss	<input type="checkbox"/> Y <input type="checkbox"/> N
Blind spots	<input type="checkbox"/> Y <input type="checkbox"/> N	Productive cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Open Wounds	<input type="checkbox"/> Y <input type="checkbox"/> N
Dry eyes	<input type="checkbox"/> Y <input type="checkbox"/> N	<b><u>Gastrointestinal:</u></b>		<b><u>Neurologic:</u></b>	
<b><u>ENT:</u></b>		Appetite changes	<input type="checkbox"/> Y <input type="checkbox"/> N	Swollen Lymph Nodes	<input type="checkbox"/> Y <input type="checkbox"/> N
Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Difficulty swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N	Easy Bruising	<input type="checkbox"/> Y <input type="checkbox"/> N
Nose bleeds	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart burn	<input type="checkbox"/> Y <input type="checkbox"/> N	Bleeding Abnormalities	<input type="checkbox"/> Y <input type="checkbox"/> N
Nasal obstruction	<input type="checkbox"/> Y <input type="checkbox"/> N	Nausea	<input type="checkbox"/> Y <input type="checkbox"/> N	Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N
Nasal discharge	<input type="checkbox"/> Y <input type="checkbox"/> N	Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N	Heat intolerance	<input type="checkbox"/> Y <input type="checkbox"/> N
Sleep apnea	<input type="checkbox"/> Y <input type="checkbox"/> N	Chronic diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Hot flashes	<input type="checkbox"/> Y <input type="checkbox"/> N
Chronic cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Constipation	<input type="checkbox"/> Y <input type="checkbox"/> N	<b><u>Immunologic:</u></b>	
Dental problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Rectal bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Syncope	<input type="checkbox"/> Y <input type="checkbox"/> N
Gingival bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Changes in bowel habits	<input type="checkbox"/> Y <input type="checkbox"/> N	Focal weakness	<input type="checkbox"/> Y <input type="checkbox"/> N
Neck pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N	Numbness	<input type="checkbox"/> Y <input type="checkbox"/> N
Neck mass	<input type="checkbox"/> Y <input type="checkbox"/> N	<b><u>Genitourinary:</u></b>		Headache	<input type="checkbox"/> Y <input type="checkbox"/> N
Frequent nose bleeds	<input type="checkbox"/> Y <input type="checkbox"/> N	Painful urination	<input type="checkbox"/> Y <input type="checkbox"/> N	Confusion	<input type="checkbox"/> Y <input type="checkbox"/> N
		Frequent urination	<input type="checkbox"/> Y <input type="checkbox"/> N	<b><u>Psychological:</u></b>	
		Vaginal bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent infections	<input type="checkbox"/> Y <input type="checkbox"/> N
		Vaginal discharge	<input type="checkbox"/> Y <input type="checkbox"/> N	HIV/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N
		Penile discharge	<input type="checkbox"/> Y <input type="checkbox"/> N	Anaphylactic reactions	<input type="checkbox"/> Y <input type="checkbox"/> N
		<b><u>Musculoskeletal:</u></b>		<b><u>Psychological:</u></b>	
		Joint pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N
		Joint swelling	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
		Muscle pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Mood swings	<input type="checkbox"/> Y <input type="checkbox"/> N
		Muscle weakness	<input type="checkbox"/> Y <input type="checkbox"/> N	Insomnia	<input type="checkbox"/> Y <input type="checkbox"/> N
		Muscle cramps	<input type="checkbox"/> Y <input type="checkbox"/> N	Stress	<input type="checkbox"/> Y <input type="checkbox"/> N
		Neck Pain	<input type="checkbox"/> Y <input type="checkbox"/> N		
		Trouble Walking	<input type="checkbox"/> Y <input type="checkbox"/> N		

Any other ailment not listed: \_\_\_\_\_

## Female Breast Health History Form

At what age did your menstrual cycles begin? \_\_\_\_\_

If you no longer have menstrual cycles, what age did you reach menopause? \_\_\_\_\_

Do you have any family members who had breast cancer?  Yes  No

If yes, what was their relationship to you? \_\_\_\_\_

Do you perform regular breast self exams?  Yes  No

If you perform routine BSE's, do you have any of the following:

abnormal nipple discharge  breast lumps

When your last mammogram?  Never had one  I have, the last one was on \_\_\_\_\_

Were the results normal?  Yes  No

### (For Breast Reduction Patients Only)

What is your height? \_\_\_\_\_ What is your current weight? \_\_\_\_\_

What is your current bra size? \_\_\_\_\_ What is your desired breast size? \_\_\_\_\_

Do you have any of the following symptoms:

Neck pain  Shoulder pain  Back pain  Shoulder grooving  Breast pain

Recurrent Rashes under your breasts  Postural problems

If you suffer from any of the above symptoms, at what age did you first notice your breasts were excessively large and started causing symptoms? \_\_\_\_\_

Have these symptoms gotten worse recently?  Yes  No

If yes, how long ago did it start getting worse? \_\_\_\_\_

Does anything exacerbate or alleviate these symptoms?  Yes  No

If yes, what makes these symptoms better? \_\_\_\_\_

If yes, what makes these symptoms worse? \_\_\_\_\_

Do you currently wear a good supportive bra?  Yes  No How long does the bra last? \_\_\_\_\_

Have you received any treatment for these symptoms?  Yes  No

If you received treatment for your ailments, which of the following have you undergone?

Physical Therapy  Chiropractic Treatments  Narcotic Pain Medications

Non-Narcotic Pain Medication  Muscle Relaxants  Rash Medications

Did you every have radiological studies of your neck/spine?  Yes  No Were the results normal?  Yes  No

If the results were abnormal, what were the abnormalities detected?

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## Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy that we ask you to read, agree to, and sign prior to any treatment.

- **Payment is due at the time services are rendered, including co-payment and deductibles.** We do bill insurance plans as a courtesy; however, it is not a guarantee of payment. We accept cash, check, Visa, MasterCard, or American Express.
- **It is your responsibility to verify with your insurance plan/carrier prior to each appointment that Dr. Perry Liu is a participating provider.** Please Verify if any services and procedures require pre-authorization. Some plans require pre-authorization or referrals from the patient's primary care physician.
- **Written or verbal Authorizations from insurance plans or management groups are not a guarantee of payment.** The insurance carriers review all claims after services are rendered and authorizations can be denied at the time of review. Denied claims become the patient's responsibility.
- **Statements are mailed after the insurance company has paid their portion.** The account is then payable within 30 days. Overdue accounts are subject to a \$15 fee. Accounts 90 days in arrears will be subject to collection by an external agency unless financial arrangements are made with our billing office.
- All supplies dispensed, which are not billable to insurance, must be paid for at the time they are dispensed.
- We recommend you verify with your insurance carrier whenever our office refers you to outside laboratories, hospitals, physical therapy, or tests to insure that you do not require any pre-authorization.

**I HAVE READ THE ABOVE AGREEMENT AND AGREE OT THE TERMS AND CONDITIONS AS SET FORTH BY PACIFIC AESTHETIC INSTITUTE.**

Patient / Responsible Party (Print Name): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Payment & Treatment Authorizations

**Authorization to pay benefits to physician and statement of responsibility:**

I hereby authorize payment directly to *Perry Liu, MD & Pacific Aesthetic Institute* of any surgical and/or medical benefits, if any, otherwise payable to me for her services. I understand that I am ultimately fully responsible for payment of services rendered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to release medical information:**

I hereby authorize *Perry Liu, MD & Pacific Aesthetic Institute* to release any information acquired during the course of my examination and treatment for the purposes of continuing my medical care or for billing/collection matters.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to treat a minor: (if applicable)**

I hereby consent to examination and treatment of \_\_\_\_\_, a minor,  
by *Perry Liu, MD & Pacific Aesthetic Institute*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to minor: \_\_\_\_\_



## **Notice Of Privacy Practices Acknowledgement**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have a certain right to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessment and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Relation to Patient

\_\_\_\_\_  
Date