PACIFIC AESTHETIC INSTITUTE

New Patient Registration

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

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	❑ Y	❑ N	Depression	❑ Y	❑ N	Hypothyroidism	❑ Y	❑ N
Arthritis	❑ Y	❑ N	Diabetes	❑ Y	❑ N	Kidney Disease	❑ Y	❑ N
Asthma	❑ Y	❑ N	Glaucoma	❑ Y	❑ N	Mitral Valve Prolapse	❑ Y	❑ N
AIDS/HIV	❑ Y	❑ N	Heart Disease	❑ Y	❑ N	Rheumatic Fever	❑ Y	❑ N
Bleeding Disorder	❑ Y	❑ N	Hepatitis	❑ Y	❑ N	Stomach Ulcer	❑ Y	❑ N
Breast Cancer	❑ Y	❑ N	High Blood Pressure	❑ Y	❑ N	Stroke	❑ Y	❑ N
Cancer	❑ Y	❑ N	Hyper-thyroidsim	❑ Y	❑ 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	❑ Y	❑ N	Depression	❑ Y	❑ N	Hypothyroidism	❑ Y	❑ N
Arthritis	❑ Y	❑ N	Diabetes	❑ Y	❑ N	Kidney Disease	❑ Y	❑ N
Asthma	❑ Y	❑ N	Glaucoma	❑ Y	❑ N	Mitral Valve Prolapse	❑ Y	❑ N
AIDS/HIV	❑ Y	❑ N	Heart Disease	❑ Y	❑ N	Rheumatic Fever	❑ Y	❑ N
Bleeding Disorder	❑ Y	❑ N	Hepatitis	❑ Y	❑ N	Stomach Ulcer	❑ Y	❑ N
Breast Cancer	❑ Y	❑ N	High Blood Pressure	❑ Y	❑ N	Stroke	❑ Y	❑ N
Cancer	❑ Y	❑ N	Hyperthyroidsim	❑ Y	❑ 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:

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

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**

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

Any other ailment not listed: _____

Female Breast Health History Form

At what age did your menstral cycles begin? _____

If you no longer have menstral 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? _____

Doe 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 ailementes, 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?

_____

_____

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: _____

Revised 11/09

PACIFIC AESTHETIC INSTITUTE

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: _____

PACIFIC AESTHETIC INSTITUTE

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

Revised 11/09