



# Patient Form

Cosmetic

## Personal Information

Name: \_\_\_\_\_ Today's Date: / /

Address: \_\_\_\_\_ Phone (H): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip : \_\_\_\_\_ Phone (C): \_\_\_\_\_

Email: \_\_\_\_\_ Phone (W): \_\_\_\_\_

Date of Birth: / / Age: \_\_\_\_\_

How did you hear about us? Internet: Google Facebook Yelp Other

Referral: \_\_\_\_\_

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

In case of emergency, who should be notified? \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

## Do we have your permission to:

Leave a message on your answering machine at home?  Yes  No

Leave a message at your place of employment?  Yes  No

Discuss your medical condition with any member of your household?  Yes  No

Send you information regarding promotions or specials we occasionally have?  Yes  No

*(We will always protect your information.)*

## Notice to Consumers:

**Medical doctors are licensed and regulated by the Medical Board of California, 800-633-2322, [www.mbc.ca.gov](http://www.mbc.ca.gov).**

## Notice of Privacy Practices Acknowledgement:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I have received 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 its Notice of Privacy Practices 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.

Patient Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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

Internal use ONLY  
 Scan  EMR  vTiger



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***We wish to welcome you to Tri Valley Plastic Surgery. We are committed to providing excellent care. Please complete as much of the information below as possible.***

What brings you to our office? Please be as specific as possible

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What medical problems do you have?

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What Surgery have you had previously?

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What allergies to medications do you have? *(Including aspirin, birth control pills, vitamins, etc.)*

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What medications do you take?

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Do you currently smoke?  Yes  No If yes, how many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Have you ever smoked?  Yes  No If yes, how many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you have any relatives who have had breast cancer?  Yes  No If yes, who? \_\_\_\_\_

Do you have a problem with excessive scarring or keloid formation after being cut?  Yes  No

Is your general health good?  Yes  No

Have you ever had psychiatric problems, or been under the care of a psychiatrist, psychologist or mental health counselor?  Yes  No

Tri Valley Plastic Surgery is a full service plastic surgery clinic with cutting edge techniques to get you the look you want safely and as inexpensively as possible.

Are there other areas you have considered improving? If so please indicate on our diagrams.

Arm Lift /Contouring

Breast Augmentation  
 Breast Lift  
 Breast Reduction

Tummy Tuck  
 Body Contouring

Labiaplasty

Brow Wrinkles

Thicker Lashes

Heavy, Tired Lids

Facial Wrinkles

Nasal Shape

Smooth Skin

Plump, Natural Lips

Neck Rejuvenation



# Consent for Medical Photography

***The Undersigned hereby consents to have photographs taken in the course of:***

1. Pre-operative evaluation and planning
2. Intra-operative or procedural documentation or evaluation
3. Post-operative documentation or evaluation

The term "photograph" as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

The undersigned acknowledges understanding that photographs may be used in the course of treatment, research, educational and informational programs as my physician deems appropriate and that such use is subject only to the following limitations:

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Date:    /    /

Time: \_\_\_\_\_

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

If by someone other than patient indicate relationship: \_\_\_\_\_

Witness: \_\_\_\_\_