

PATIENT INFORMATION

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (Local): \_\_\_\_\_ City \_\_\_\_\_ Zip: \_\_\_\_\_ Hm. Ph. \_\_\_\_\_ Cell Ph. \_\_\_\_\_

Address (Mainland): \_\_\_\_\_ City \_\_\_\_\_ Zip: \_\_\_\_\_ Hm. Ph. \_\_\_\_\_ Other Ph. \_\_\_\_\_

Sex:  Male,  Female Marital Status:  Single,  Married,  Separated,  Divorced  Widowed

Spouse or  Parents' Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Person Responsible for Bill: \_\_\_\_\_ Relationship: \_\_\_\_\_

Billing Address: \_\_\_\_\_ Zip: \_\_\_\_\_ Hm. Ph. \_\_\_\_\_ Other Ph. \_\_\_\_\_

Patient or Guardian's Employer & Occupation: \_\_\_\_\_

Employment Status:  PT student,  FT student,  PT work,  FT work,  Medical Leave of absence,  Retired,  Active Military –USA,  Active Military – Overseas,  Minor not of school age Patient's Employer's Ph #: \_\_\_\_\_

Guardian's Status (if patient is under 18):  PT student,  FT student,  PT work,  FT work,  Medical Leave of absence,  Retired,  Active Military –USA,  Active Military – Overseas,  Minor not of school age Guardian's Employer's Ph #: \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_

Patient's Regular Physician & Clinic Name: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred to us? : \_\_\_\_\_

MEDICAL INFORMATION

Medical Problem or Reason for Today's Visit: \_\_\_\_\_

Date of Injury (if applicable): \_\_\_\_\_ How were you injured? \_\_\_\_\_

Related to work? \_\_\_\_\_ Auto Accident? \_\_\_\_\_

Are you being treated for any ongoing or chronic conditions? \_\_\_\_\_

INSURANCE INFORMATION

Medical Insurance (1): \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Policy Holder Social Security Number: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Group Number: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Medical Insurance (2): \_\_\_\_\_ Identification Number: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Policy Holder Social Security Number: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

PRIOR TO TREATMENT, PLEASE READ CAREFULLY AND SIGN BELOW

- I Herby authorize the release of medical and billing information, by Carl L. de los Reyes, M.D., to my treating physician(s), insurance company, and the responsible party named above on behalf of myself and/or my dependents, as necessary for the continuation of my medical care. I also agree to pay, in a current manner, any balance of professional service charges over and above my insurance payments.
- I understand that I am responsible for any amount not covered by my insurance. If my account is sent to an outside collection agency for nonpayment, I understand that I will be charged an additional 50% of the amount due on my account for collection fees.

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

I HAVE BEEN MADE AWARE OF MY RIGHTS AND REVIEWED A COPY OF THE HIPAA PRIVACY POLICY.

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

**Carl L. de los Reyes, MD  
CdR Plastic Surgery, Inc.  
1329 Lusitana Street, Suite 807  
Honolulu, HI 96813**

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

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

**ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY**

I request that payment of authorized insurance Company/Medicare benefits be made on my behalf to **Carl L. de los Reyes, M.D.** for any services furnished to me by him I further authorize **Carl L. de los Reyes, M.D.** to release to my health insurance carrier(s) or the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services which may include information on sexually transmitted diseases, any labs including HIV results, psychiatric information, or any substance or alcohol abuse. My signature below authorizes my physician to submit claims without my signature on each and every claim to be submitted.

I understand that I am responsible for any amount not covered by insurance.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE

**MEDICAL RECORDS RELEASE**

I hereby understand that the release of medical records from **Carl L. de los Reyes, M.D.** needs to be requested by completing a medical records release form. I also understand that a processing fee of \$.50 per page will be charged.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE

**APPOINTMENT CANCELTION, SURGERY CANCELTION & NO SHOW FEES**

I hereby understand that I will be charged and agree to pay the following

• \$25 if I do not show up for an office appointment or cancel within 24 hours of a scheduled appointment.*	• \$100 for cancellation of a medically insured surgery.*
• Loss of deposit for cancellation of a cosmetic surgery.*	*Fee waived if cancelled for a documented personal medical reason.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE

**PAYMENT AGREEMENT**

All charges are due at time of service, unless other arrangements have been made in advance. I understand that I am responsible to Carl de los Reyes, MD or CDR Plastic Surgery, Inc. for deductibles and copayments required by my insurance company and fees that may not be covered by insurance or this agreement. I further agree that in the event of non-payment, I will bear the expenses of collection and/or court costs and reasonable legal fees should this be required.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE

**HIPAA AUTHORIZATION TO RELEASE RECORDS**

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization (***check all that apply***):

All medical records

or

All medical records except:

Clinical notes

HIV test results

Genetic test results

Lab/Imaging Reports

Restrict to the following dates/conditions: \_\_\_\_\_

X-ray Film(s)

Other (*specify*) \_\_\_\_\_

2. The doctor and his/her staff have my permission to speak to the following spouse, family member, relative or friend regarding my medical information and treatment.

<u>Name</u>	<u>Relationship</u>	<u>Name</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then the information may be re-disclosed and would no longer be protected.

4. This authorization gives the doctor and his/her staff permission to leave messages regarding my appointments or health information on my answering machine/voice mail.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (e.g. a letter) addressed to the doctor. I am aware that my revocation is not effective to the extent that persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization shall cover the period of time from my first visit to my last visit. I release the doctor and staff from all legal responsibility that may arise from this authorization.

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the doctor, nor will it affect my eligibility for benefits.

8. My protected health information will be used or disclosed upon request for the following purposes (*check as many as apply*):

Personal records

Continued medical care

Insurance claim

Legal Action

Other (*specify*) \_\_\_\_\_

9. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations:

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

# History Intake Form

**Patient Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

**Primary Care Doctor:** \_\_\_\_\_

Approximate type & amount per day of **Alcohol** \_\_\_\_\_ **Coffee** \_\_\_\_\_ **Aspirin** \_\_\_\_\_

If former smoker, date quit: \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_

**List Drug allergies:** \_\_\_\_\_

**List previous surgeries or major illnesses and dates:** \_\_\_\_\_

**List any medications you are taking, including non-prescription drugs, vitamins, and herbals:** \_\_\_\_\_

## **Family History:**

Has any blood relative ever had the following:

Breast Cancer .....	no	yes	High blood pressure ....	no	yes	Kidney disease .....	no	yes
Melanoma .....	no	yes	Heart Disease .....	no	yes	Depression .....	no	yes
Stroke .....	no	yes	Diabetes .....	no	yes	Colon Cancer .....	no	yes

## **Past Medical History**

Have you ever had the following:

Heart disease .....	no	yes	Cancer .....	no	yes	Stomach Ulcer .....	no	yes
Arthritis .....	no	yes	Glaucoma .....	no	yes	Kidney disease .....	no	yes
Rheumatic Fever .....	no	yes	Asthma .....	no	yes	Thyroid Disease .....	no	yes
Anemia .....	no	yes	AIDS or HIV + .....	no	yes	Bleeding tendency .....	no	yes
Tuberculosis .....	no	yes	Stroke .....	no	yes	Mitral Valve Prolapse .....	no	yes
Diabetes .....	no	yes	Hepatitis .....	no	yes	High Blood Pressure .....	no	yes

## **Review of Systems**

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

Weight Change .....	no	yes	Swollen feet/ankles ....	no	yes	Seizures .....	no	yes
Dry eyes .....	no	yes	Skin rash .....	no	yes	Joint or muscle pain .....	no	yes
Chronic cough .....	no	yes	Chronic diarrhea .....	no	yes	Swollen lymph nodes .....	no	yes
Chest pan .....	no	yes	Jaundice .....	no	yes	Easy bleeding .....	no	yes
Rapid heart beat .....	no	yes	Depression .....	no	yes	Easy bruising .....	no	yes

## **Women only: Bra size:**

Age period began

Date of last mammogram

Do you do regular breast self-examinations

Number of pregnancies.

Did you breast feed? .....

Breast lump or discharge .....

**I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
Signature of patient or guardian if minor

\_\_\_\_\_  
Date

**PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE**

I consent to the use of photographs taken by Dr. Carl de los Reyes or his designee of me or parts of my body in connection with the plastic surgery procedures(s) performed by Dr. de los Reyes. I further consent to the use of these photos for educational purposes.

I understand that such photographs may be published by Dr. de los Reyes in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features which shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. de los Reyes.

I understand that by signing this consent the information disclosed, or some portion thereof, may no longer be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge Dr. de los Reyes, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

*Patient* (Print Name) \_\_\_\_\_ *Date* \_\_\_\_\_

*Patient Signature* \_\_\_\_\_

WITNESS/PHYSICIAN: \_\_\_\_\_

I have read the above Authorization and Release. I am the parent, guardian or conservator of

\_\_\_\_\_, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

*Parent/Guardian* \_\_\_\_\_ *Date* \_\_\_\_\_