Miller Cosmetic Surgery
9834 Genesee Avenue # 210
La Jolla, CA 92037
858-453-3133
www.millercosmeticsurgery.com

Patient Information Form

Patient Name: _____

Address: _____ City: _____
State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Carrier: _____

Patients Age: _____ Marital Status: S M D W DOB: _____

Sex: F M SSN: _____ Email Address: _____

Occupation: _____ Employer: _____

Employer Address: _____ Work Phone: _____

Primary Care Physician and phone number _____

How did you hear about Dr. Miller?
- ___ Patient Referral: _____
- ___ Friend: _____
- ___ Dr. Referral: _____
- ___ Other: _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ___ Spouse ___ Parent/Guardian ___ Other: _____
Home Phone: _____ Cell: _____

Patient Insurance Information

For Emergency purposes only
Insurance Company Name: _____ Relationship to Insured: _____
Group # _____ ID # _____
Insurance company Phone Number: _____

Please be advised, Dr. Miller does not accept Medicare or any other insurance. Any procedure provided by Dr. Miller will not be billable, not by our office nor by the patient for personal reimbursement. We are unable to provide coding or any insurance billing support of any kind.

Patients initials _____

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Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

Section II: Specific Medical History

1 Are you pregnant? ☐ No ☐ Yes Height: Weight:

	Have you or do you still have:	No	Yes	Description
2	Asthma, chronic bronchitis	☐	☐	
3	Emphysema or other lung problems	☐	☐	
4	High Blood Pressure	☐	☐	
5	Heart disease (angina, arrythmias or heart attack)	☐	☐	
6	Hepatitis or Liver problems	☐	☐	
7	Kidney problems	☐	☐	
8	Diabetes	☐	☐	
9	Epilepsy or Seizures	☐	☐	
10	Stroke	☐	☐	
11	Stomach or intestinal problems	☐	☐	
12	Bleeding disorders	☐	☐	
13	Autoimmune disease	☐	☐	
14	HIV	☐	☐	
15	Herpes (fever blisters)	☐	☐	
16	Have you been advised to or had psychiatric care?	☐	☐	
17	Others not listed			

Are there any other medical or non-medical conditions that we should know about in order to better care for you?

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Section III: Social History

1. Do you smoke or vape? ___ No ___ Yes, how much? _____
2. Do you drink? ___ No ___ Yes, how much? _____
3. Do you have children? ___ No ___ Yes, how many? _____

Section V: Medications

Are you taking any medications (including asprin, ibuprofen vitamins or herbal supplements?) ___ No ___ Yes please list:

_____

_____

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ___ No ___ Yes, please list:

_____

_____

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

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Consent to Communicate

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders				
☐ Email Medical Info				
	-	-	☐	-
☐ Mail to Address: ☐ Home ☐ Other (please list):		☐ Please **do not** send paper mail	☐	
	-	-		-

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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HIPAA Information and Consent Form

Patient Name: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____