DESERT HILLS
PLASTIC SURGERY CENTER

10001 South Eastern Avenue, Suite 406
Henderson, Nevada 89052

Patient Registration Form

(Please Print All Information)

Date: _____ Age: _____ Sex: _____

Name _____ Date of Birth _____

Social Security Number (SSN#) _____ / _____ / _____ Phone # _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Employer _____ Marital Status _____

Address _____ Phone # _____

City _____ State _____ Zip _____

Email address _____

How did you hear about our office? ☐Doctor _____ ☐Internet _____ ☐Real Self _____ ☐Other _____

Spouse/Parent Name _____

Address _____ City _____ State_____ Zip _____

In Case of Emergency Name _____

(Nearest Relative not living with you, or Personal Contact)

Relation to Patient _____ Phone #_____ Work Phone #_____

Primary Insurance _____ Phone #_____

Policy Holder's Name _____ Birth Date _____ /_____ / _____

Group # _____ ID # _____

WE WILL NEED A PICTURE I.D.
WE MAY ASK FOR A COPY OF YOUR INSURANCE CARD, IF NECESSARY

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Patient Information and Health History

Date:_____

Patient Name:_____

Birth Date:_____ Age:_____

Email address:_____

Referred By:_____

Primary Care Doctor:_____

Reason for Visit:_____

List Medical Problems or Illnesses:_____

_____

_____

List **All** previous Cosmetic Surgeries or Procedures (with relevant dates if known):_____

_____

List **All** other Surgeries

_____

_____

Have you ever had problems or complications associated with previous surgery or anesthesia? Yes No (circle one).
If yes, describe:

_____

_____

List any medications you are taking, including vitamins or herbal medicines:_____

_____

List any allergies to any medicines or materials:_____

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PAST MEDICAL HISTORY

Have you ever had any of the following? (Please circle the appropriate response)

Heart Disease	Yes	No	Heartburn/reflux	Yes	No
Lung Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Diabetes	Yes	No	Breathing Difficulties	Yes	No
MRSA(Staph Infections)	Yes	No	Cold Sores	Yes	No
High Blood Pressure	Yes	No	Varicose Veins	Yes	No
Asthma	Yes	No	Joint Replacement	Yes	No
Blood Clots in legs	Yes	No	Skin Cancer	Yes	No
Shingles	Yes	No	If (Yes), Where?_____		
Accutane use	Yes	No	Arthritis	Yes	No
HIV or Aids	Yes	No	Thyroid Disease	Yes	No
Hepatitis	Yes	No	Kidney Disease	Yes	No
Stroke	Yes	No	Inflammatory Bowel Disease	Yes	No
Mental Illness	Yes	No	Addiction/Substance Abuse	Yes	No

FAMILY HISTORY

Have any of your relatives had any of the following? (Please circle the appropriate response)

Breast Cancer	Yes	No	Addiction/Substance Abuse	Yes	No
Melanoma	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Mental Illness	Yes	No
High Blood Pressure	Yes	No	Bleeding Disorder	Yes	No
Blood clots (DVT)	Yes	No	Cancer	Yes	No
Diabetes	Yes	No	If so, what kind? _____		
Kidney Disease	Yes	No	Any other? _____		

OPHTHALMOLOGIC HISTORY

Do you have any of the following?

Abnormal Visual Acuity	Yes	No	Near or Farsighted (*please circle one*)	Yes	No
Glasses	Yes	No	Dry Eyes	Yes	No
Contacts	Yes	No	Edema	Yes	No
Glaucoma	Yes	No	Cataracts	Yes	No
Visual Field Disturbance	Yes	No	Tearing	Yes	No
Facial Muscle/Nerve Problems	Yes	No	Allergies	Yes	No
Previous Eye Surgery	Yes	No			
If yes, what kind?_____					

REVIEW OF SYSTEMS

Have you had any of the below listed symptoms in the past year?

Fever & Chills	Yes	No	Abdominal Pain	Yes	No	Swollen Feet	Yes	No
Skin Lesion/Rash	Yes	No	Chronic Cough	Yes	No	Constipation	Yes	No
If yes, where:_____			Headache	Yes	No	Heartburn or Reflux	Yes	No
Dry Eyes	Yes	No	Sore Throat	Yes	No	Breast Lump	Yes	No
Ear Infection	Yes	No	Taken Steroids	Yes	No	If (Yes) Where_____		
Sinusitis	Yes	No	Depression	Yes	No	Any Biopsy?_____		
Joint or Muscle Pain	Yes	No	Easy Bruising or Bleeding	Yes	No	Seizures	Yes	No
If (Yes) Where_____			Wheezing	Yes	No	Wear Contact Lenses	Yes	No
Urinary Infection	Yes	No	Anxiety	Yes	No	Keloid Scarring	Yes	No
Back Pain	Yes	No	Neck Pain	Yes	No	Dentures	Yes	No
Hypertrophic Scarring	Yes	No	Pigmented (dark) scars	Yes	No	Skin sensitivity	Yes	No
Breast Pain	Yes	No	Severe allergies	Yes	No	Motion Sickness	Yes	No
Chest Pain	Yes	No	Acne/frequent breakouts	Yes	No	Nausea with Medications/ Anesthesia	Yes	No

Weight Change / Gain _____ Loss _____ Current Weight_____ Height _____
Ethnicity_____ What is your Ideal/Realistic Weight?_____

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SOCIAL HISTORY

Job Description: _____

Employer: _____

Do you or did you ever smoke cigarettes? Yes No If so, how many packs per day? _____

When did you quit? _____

Alcohol Use? Yes No # of Alcohol drinks per week? _____

Recreational Drug use? Yes No What kind? _____

Cannabinoids (Marijuana) use? Yes No What Kind? _____ (Smoke or edible)

How often? _____ Other _____

Married Or Single (circle one)

Exercise Routine: _____

Dietary Habits/Preferences: _____

Hobbies or Activities you enjoy: _____

Do you have any special events coming up that you want to look great for? (for example, reunion, wedding, trip)

_____

When is the event?_____

What are the top two things you like least about your body?_____

What are the top two things you like least about your face?_____

WOMEN ONLY

Number of pregnancies _____ Any problems or complications with previous pregnancy? Yes No

If yes, describe: _____

Date of last menstrual period _____

Number of children _____Date of last Mammogram (xray) study_____

Did you breast feed? Yes No, Do you do regular breast self- examinations? Yes No

Are you planning on more children? Yes No, Do you want to breast feed more children? Yes No

SKIN EVALUATION *What best characterizes your skins reaction to sun exposure (without sunscreen). Check the most appropriate response.*

_____ 1) Always burns, never tans
_____ 2) Usually burns, tan with difficulty
_____ 3) Sometimes mildly burns, tans average
_____ 4) Rarely burns, tans with ease

Describe your current facial/skin care regimen:

_____

_____

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NON-SURGICAL TREATMENTS ***Have you had any of the following? Yes or No***

Botox/Dysport/Xeomin Yes No If yes, when was your last treatment? _____

How long did it last? ____months.

FILLERS ***Have you had any of the following? Yes No***

Belotero Yes No What area? _____When was your last treatment?_____

Radiesse Yes No What area?_____ When was your last treatment?_____

Voluma Yes No What area? _____ When was your last treatment?_____

Bellafil/Artefill Yes No What area? _____When was your last treatment?_____

Restylane Yes No What area? _____When was your last treatment?_____

Sculptra Yes No What area? _____When was your last treatment?_____

Juvederm Yes No What area? _____ When was your last treatment?_____

Fat Injections Yes No What area?_____

Other Injectable Material Yes No What kind? _____

Location? _____ When? _____

SKIN RESURFACING ***Have you had any of the following? Yes No***

Laser Treatments Yes No If yes, what kind? _____ When?_____

Chemical Peels Yes No If yes, what kind? _____ When?_____

Surgical Dermabrasion (not microdermabrasion) Yes No If yes, when?_____

WHAT COSMETIC SURGERY PROCEDURES HAVE YOU DONE BEFORE AND **LIKED?**

_____

_____

WHAT COSMETIC SURGERY PROCEDURES HAVE YOU DONE BEFORE AND **DISLIKED?**

_____

WHAT ARE YOU INTERESTED IN TRYING?

_____

WHEN DO YOU WANT TO DO SURGERY OR YOUR PROCEDURE? (CHECK ONE)

____ As soon as possible ____ One week _____ One month ____ Two months _____ 4 months _____ 6 months

_____ A particular date or season (please name):_____

WHAT IS YOUR BUDGET OR HOW MUCH DO YOU WANT TO SPEND? $_____

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CONTACT INFORMATION

I wish to be contacted in the following manner (check that apply):

( ) Home telephone _____
( ) o.k. to leave message or talk to other family members about my medical condition.

( ) Work number _____
( ) Leave message with call back number only

( ) Cell telephone _____
( ) o.k. to leave message with detailed information.

( ) Email Address: _____

_____ _____
Signature Date

==========

FOR OFFICE USE ONLY: HISTORY REVIEWED BY: DATE:

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Financial Policy - Cosmetic / Cash Patient

Initial cosmetic consultations are charged a $75 non-refundable fee, which will be subtracted from the overall surgery total if you decide to proceed with surgery. This charge is due the same day as your initial cosmetic consultation. Secondary consultations to "re-discuss" the initial consultation are free of charge if scheduled within 90 days of the initial consultation. If scheduled after the 90 day period following the initial consultation, a $75 non-refundable fee will be collected at the time of the secondary consultation.

Payment for all treatments and services are to be paid in full prior, **no exceptions**. If you are having an in-office procedure or an outpatient surgery that is two hours or less, you will be asked to pay a **non-refundable** deposit of $500.00. If your surgery exceeds two hours, you will be asked to pay a **non-refundable** deposit of $1000.00. An additional $500.00 deposit will be charged for all rescheduled surgeries. The paid deposit(s) will be subtracted from your total surgery cost. Your surgery cannot be scheduled until the deposit is received. The remainder of the monies will be collected at your pre-operative visit. **NO EXCEPTIONS**.

We accept Visa/MasterCard/American Express/Discover, cash or a cashier's check payable to Desert Hills Plastic Surgery Center or Dr. Hayley Brown. **NO PERSONAL CHECKS ACCEPTED.** If you cancel your surgery before 2 business days of your scheduled surgery, you will be refunded the amount paid, *minus* the non-refundable scheduling deposit(s). If you cancel your surgery within 2 business days of your scheduled surgery, you will be refunded the amount paid *minus* $2000.00. If your surgery is cancelled due to a documented medical condition, you will be refunded the amount paid, minus the non-refundable $500.00 or $1000.00 surgery scheduling deposit(s).

If you are financing your surgery, the $500.00 or $1000.00 non-refundable deposit is still required. Should you decide to cancel your surgery, we will refund your finance company the amount financed, minus the non-refundable deposit(s).

From time to time, as an executive decision, billing and costs may be waived to aid in the care and treatment of patients. Nothing in this decision or act shall be construed as an admission of negligence or substandard care but only an assistance to facilitate patient care.

By signing this financial policy agreement, I consent to waive my right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) guidelines in the event of a financial dispute for any and all treatment or procedures performed.

Please ask for a receipt if one is not given to you.

_____ _____

Patient Signature Date

_____ _____

Signature of Witness Date

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Smoking, and the Surgery Patient

I have been informed of the danger of smoking prior to having surgery. Scientific study has shown that smoking decreases the circulation to the skin. Those who insist on smoking during the period of healing have a great increase in complications resulting in skin necrosis or poor healing, skin loss, delayed healing with open wounds, worsened or additional scarring of the skin, bleeding, need for prolonged wound care/dressings, and poor take of any filler material (such as Collagen, Restylane/Juvederm, or fat).

For Facelift, Abdominoplasty, and Breast Lift/Reduction Patients: You must stop smoking 6 weeks prior to, and 3 weeks after surgery.
This includes all Nicotine, Tobacco products: gum, patch, secondhand smoke, etc, which also decrease circulation to the skin.

I verify that I have been informed of these complications and that I should stop smoking 3-6 weeks prior to, and 3 weeks after surgery.

I understand the above information and I :

Do not smoke _____
Patient's Signature

Will quit smoking for the prescribed time _____
Patient's Signature

Will Not quit smoking For the prescribed time _____
Patient's Signature

Date: _____

Witness: _____

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NOTICE OF PRIVACY PRACTICES
Effective 4- 14-2003

This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review it carefully.

This page describes the type of information we gather about you, with whom that information may be shared and the safeguards we have in place to protect it. You have
the right to the confidentiality of your medical information, and the right to approve or refuse the release of specific information except when law requires the release, or permitted by law without your authorization.

If you have questions about this notice, please contact our Privacy Officer at the above address.

This notice describes the Provider's practices regarding the use of your medical information and that of:

- Any health care professional employed by Desert Hills Plastic Surgery Center who is authorized to enter information into your medical record.
- Any member of a volunteer group we allow to help you.
- All employees, staff, and other personnel who may need access to your information.
- If we have, or in the future will have, multiple sites or locations, all of them will adhere to the provisions in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of personal medical information. We are required by law to:

- Keep confidential any medical information that concerns your condition or treatment, how your care is paid for, and demographic information, if such information can be used to identify you;
- give you this notice of our policies, procedures and information privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

HOW WE MAY USE & DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following listed are different ways that we may use and disclose information about you. If you require examples please ask for more information. **For Treatment, For Payment, For Health Care Operations Purposes, Appointment Reminders, Treatment Alternatives, Health –Related Benefits and Services, Individuals Involved in Your Care or Payment for Your Care, Research, As Required By Law,
To Avert A Serious Threat to Health Or Safety, Fundraising Activities, Organ and
Tissue Donation, Military & Veterans, Workers Compensation, Public Health Risks, Health Oversight Activities, Lawsuits and Disputes, Law Enforcement,
Coroners, Medical Examiners, and Funeral Directors, Inmates in the Custody
Of Law Enforcement.**

Where Nevada law and HIPAA regulations conflict, we will abide by the more stringent provision protecting your personal health information.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect & Copy. You have the right to inspect and copy medical information that may be used to make a decision about your care. This includes medical and billing records, excludes psychotherapy notes. If you choose to do so, you must submit your request in writing to our Privacy Officer. A copying fee will apply, or other unusual supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied, you may request that the denial be reviewed and the next appropriate step will be taken.

Right to Amend. If you feel that the medical information we have about you is incorrect or incomplete, you have the right to request an amendment for as long as the information is kept.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, we may deny your request but will notify in writing as to the reason.

Right to an Accounting Of Disclosures. You have the right to request an "accounting of disclosures." This is a list of disclosures we made of medical information about you.
This accounting will not include many routine disclosures.

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To request this list, you must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates prior to April 14, 2003. A fee may apply.

Right to Request Restrictions. You have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or for the payment of your care, like a family member or friend. We are not required to agree with your request. If we do agree we will comply with your request unless the information needed is to provide you with emergency treatment. To request restrictions, you must make your requests in writing to our Privacy Officer and they will give you further instructions.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. However, if complying with your requests entails additional expense over our usual means of communication, a fee may apply.

Right to a Paper Copy of this Notice. You have a right to a copy of this notice.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the Patient Education Room. The notice will contain, on the first page, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint, contact our Privacy Officer at the address and phone number below. All complaints must be in writing. You will not be penalized for filing a compliant.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made under your authorization. We are required to retain our records of the care that we provided to you for six years.

PRIVACY OFFICER

The Provider's Privacy Officer is:
Raquel Bosze c/o Desert Hills Plastic Surgery Center
10001 South Eastern Avenue, Suite 406
Henderson, NV 89052 (702) 260-7707 Phone (702) 990-1972 Fax

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ACKNOWLEDGEMENT

I hereby acknowledge that I have been presented this notice of Privacy Practices.

Signature: _____ Date: _____

Print Name: _____

I authorize Dr. Hayley Brown to use or disclose my protected health information and all other information necessary to carry out treatment or obtain payment. (medical doctors and/or specialist, collection agencies, insurance companies).

_____I authorize correspondence including postcards, email and text messages to be sent to me.

_____I authorize the release of information regarding my treatment to my spouse and/or significant other.

_____I do NOT want any of my information disclosed without my written consent

List any family members, relatives and/or friends that may discuss or request your medical information.

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____