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

Hawaii Plastic Surgery Institute

Bao L. Phan, M.D.

**PLEASE** WRITE OR PRINT CLEARLY

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_ /\_\_\_\_ /\_\_\_\_ Age: \_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_ -\_\_\_\_ - \_\_\_\_\_\_\_\_\_ Sex: Male Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ ⁭Home ⁭Cell ⁭Work

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_

Married / Single / Divorced Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_

**If patient is a minor, full-time student, or not the responsible party:**

Guarantor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_

Have you or another family member been seen in this office before? Yes No If yes, name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION (if applicable)**

Primary Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_

Insured Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_ /\_\_\_\_ /\_\_\_\_ SS#: \_\_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

Insured Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_ /\_\_\_\_ /\_\_\_\_ SS#: \_\_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

1. Are you allergic to any drugs or foods? List all ⁭ Yes ⁭ No

2. Do you take any medications regularly? List all ⁭ Yes ⁭ No

3. Do you take any non-prescription or herbal medications or use any illegal substances? List all ⁭ Yes ⁭ No 4. Have you ever had an operation? List all ⁭⁭ ⁭ Yes ⁭ No

5. Have you ever been hospitalized for a serious illness? List all ⁭ Yes ⁭ No

6. Have you ever had any breathing difficulties such as asthma, emphysema, chronic cough, pneumonia, tuberculosis, or any other disorder? ⁭ Yes ⁭ No

7. Do you smoke or use smokeless tobacco? ⁭ Yes ⁭ No If yes, How much and how often?

 Do you drink alcohol? ⁭ Yes ⁭ No If yes, How much and how often?

8. Do you have or have you had Temporomadibular joint (TMJ) Problems (clicking, popping, or pain)? ⁭ Yes ⁭ No

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CONTINUED

9. Do you have or ever had? (check correct box):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Heart Trouble / Heart Murmur | Yes | No | Positive HIV Test | Yes | No |
| Rheumatic fever | Yes | No | Acquired Immune Deficiency (AIDS) | Yes | No |
| Stroke | Yes | No | Asthma/ Emphysema | Yes | No |
| High Blood Pressure | Yes | No | Hepatitis/ Liver Trouble | Yes | No |
| Diabetes | Yes | No | Implant placed anywhere in your body | Yes | No |
| Kidney Disease | Yes  | No | Anemia | Yes | No |
| Arthritis | Yes | No | Profuse Bleeding or Easy Bruising | Yes | No |
| Recent Colds | Yes  | No |

10. Are you using or taking any of these? (check correct box):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Antibiotics or Sulfa Drugs | Yes | No | Anticoagulants (blood thinners) | Yes | No |
| High Blood Pressure Medications | Yes | No | Steroids | Yes | No |
| Insulin or Oral Diabetic Medications | Yes | No | Aspirin | Yes | No |
| Marijuana, Cocaine, other “Street Drugs” | Yes | No | Motrin, Ibuprofen, Aleve or other NSAIDs | Yes | No |

11. Are you subject to fainting, nervous disorders, convulsions or epilepsy? ⁭ Yes ⁭ No

12. **Women:**

**A**. If you are using oral contraceptives it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills during and after the course of antibiotics or other medications is completed. Please consult your primary care physician for further guidance.  **B**. If you are pregnant, possibly pregnant or trying to become pregnant, then surgery, anesthetics or any other medication may harm your developing baby, especially during the first trimester. Please inform the doctor if there is any chance that you might be pregnant.

**C**. Are you pregnant? ⁭ Yes ⁭ No **D.** Do you wish to have a pregnancy test? ⁭ Yes ⁭ No

13. Has there been any change in your general health in the past year?

14. Are you under the care of a physician for a particular problem?

15. Your primary/ family physician’s name is:

 Office location (city): Date of last physical:

16. Who referred you to our office?

17. What is the reason for seeing the Doctor today?

18. Name of nearest relative not living with you: Phone: ( ) -

 Address: City: State:

I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES ARISING FROM SERVICES DELIVERED AND I AUTHORIZE PAYMENT OF ANY MEDICAL INSURANCE BENEFITS (IF APPLICABLE) TO HAWAII PLASTIC SURGERY ASSOCIATES. I CONSENT AND AUTHORIZE THE RELEASE OF ANY MEDICAL HEALTH INFORMATION TO APPROPRIATE ENTITIES NECESSARY FOR PURPOSES OF TREATMENT, PAYMENT &/ HEALTH CARE OPERATIONS NEEDED TO PAY FOR MY SERVICES &/ PROCESS MY CLAIM (IF APPLICABLE).

HAWAII PLASTIC SURGERY INSTITUTE IS COMMITED TO PROTECTING YOUR MEDICAL INFORMATION.

Signature Date: