

MEDICAL AND SURGICAL HISTORY

MICHAEL C. EDWARDS, MD, FACS

EDWARDS PLASTIC SURGERY

Name: _____ Date: _____ Age: _____ Birth date: _____

What brings you to see Dr. Edwards today? (Please check the box(s) that apply to you)

- **Breast Surgery:** Enlargement Lift Breast Reduction Asymmetry Implant Revision
- **Body Contouring:** Tummy Tuck Body Lift Buttock Lift Thigh Lift Arm Lift
- **Liposuction:** Abdomen Flanks Upper back Thighs (Inner/Outer) Lower Back Arms
- **Other:** _____

What are your goals from this visit & apart from surgery? _____

Please explain how you have managed this concern? _____

CHIEF COMPLAINT (Dr. Edwards will fill this in): _____

Breast CA Risk Factors (for women): 1. How old were you when you started periods? _____ 2. How old were you with your 1st pregnancy; _____ 3. Is there a **family history** of breast cancer? N Y (please explain) _____

4. Are you still having periods? Y N Date of your last **mammogram**: _____

How many pregnancies have you had? ____ **How many live deliveries have you had?** ____ [C-section ____ Vaginal ____]

Have you had any miscarriages or stillbirths? **How many?** _____

PAST MEDICAL HISTORY (please fill out completely)

Who is your **Primary Care Doctor**? _____

Do you see any **specialists**? _____

Do you smoke? Y N If yes, how much do you smoke and for how long; _____

MEDICATIONS: Please list all medications that you take. (This should include **any and all medications** that you take including those you get from a physician, over the internet, over the counter, from another healthcare provider or from **ANY** health food stores. Please list the medication, dose, & how often you take it.

Do you have any **allergies** to medications or **latex**? Please list them & the reactions that you had. NKDA

How much alcohol do you drink per week? _____ Caffeine or Soda? _____

SOCIAL HISTORY: What kind of work do you do? _____

CHILDHOOD ILLNESSES: Did you have any serious illnesses, surgeries or hospitalizations as a child? Y N

(Please describe) _____

FAMILY HISTORY: Is there any history of any of the following problems in blood relative family members?

Diabetes Arthritis Asthma or lung disease Anesthesia complications Breast Cancer Cardiac Cancer

High blood pressure Bleeding or Clotting tendencies Other: _____

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REVIEW OF SYSTEMS: (Check any of these conditions if you **currently** have them)

GENERAL: Chills Depression Dizziness Fainting Fever Forgetfulness Headache/ Migraines Sweats Loss of sleep Loss of weight Weight gain Nervousness Anxiety Numbness _____

MUSCULOSKELETAL: Pain or weakness of the Neck Back Arms Hands Hips Legs Feet

GENITOURINARY: Blood in urine Frequent urination Bladder Infections Lack of bladder control Painful urination Kidney Stones _____

GASTROINTESTINAL: Poor appetite Bloating Bowel changes Constipation Diarrhea Indigestion Nausea Vomiting Rectal bleeding Gastric Reflux Ulcers _____

CARDIVASCULAR: Chest pain High blood pressure Low blood pressure Irregular heart beat Poor circulation Rapid heart beat Heart attack Varicose veins _____

Have you ever been told you need antibiotics for surgery or dental work because of a heart murmur? Y N

EYE, EAR, NOSE, THROAT: Blurred vision Vision flashes Double vision Ringing in the ears Loss of hearing Nose bleeds Sinus problems Difficulty swallowing Hoarseness Bleeding gums _____

RESPIRATORY: Persistent or chronic cough Shortness of breath at rest or with exercise Do you ever cough up blood? Wheezing Do you lose your breath with minor exertion? Abnormal chest x-ray _____

PSYCHOSOCIAL STRESS: Recent death in the family Current or previous legal action Recent Marriage / Divorce / Birth Change in job or residence _____

SKIN: Bruise easily Hives Itching Change in moles Rash Sores that won't heal _____

WOMEN ONLY: Breast lump(s) Nipple discharge Abnormal mammogram _____

Is it possible that you are pregnant? Y N _____

ADULT ILLNESS: Do you have or have you ever had any of the following conditions/diagnoses?

AIDS/ HIV positive Alcoholism Anemia Anorexia Arthritis Asthma Bleeding Bulimia Bronchitis Cancer Diabetes Emphysema Epilepsy Glaucoma Goiter Gout Hepatitis Heart disease Hernia Herpes High Blood Pressure High cholesterol Migraine Headaches Kidney disease(s) Liver disease Mono Multiple sclerosis Pacemaker Pneumonia Prostate problem Have you ever been treated for anxiety or depression? Have you ever been hospitalized for psychiatric reasons? Rheumatic fever Scarlet fever Stroke Thyroid problems Ulcers Deep Vein Thrombosis (DVT) Pulmonary Embolus _____

Have you had any vaccine series Y N: Hepatitis A Hepatitis B **Have you had titers drawn?** Y N

PAST SURGICAL HISTORY: (please list surgeries that you have had (when, where & why)

NOTES:

Michael C. Edwards, MD, FACS

AUTHORIZATION FOR EXAMINATION

Name: _____ Birthdate: _____

Address: _____

City/State/Zip Code: _____

Home Phone: _____ Cell Phone: _____

Referred By: _____

I, _____, represent to Dr. Edwards and his staff that I am at least 18 (eighteen) years of age, an emancipated minor or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by Dr. Michael C. Edwards and such assistants or staff as may be assigned by him.

I authorize the release or receipt of any of my medical information as necessary for my care and treatment. I authorize payments of medical benefits directly to Dr. Michael C. Edwards for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising in the course of my treatment, I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating the outcome of cosmetic or reconstructive surgery. I authorize taking of photographs by or at the direction of Dr. Michael C. Edwards. These photographs will be used for documentation purposes and additional consent will be required for any other use (please refer to the photography consent).

CONSULTATION FEE

I understand that there is a \$50.00 consultation fee for the initial visit. This fee is due at the time of my appointment being scheduled. If a surgical procedure is scheduled within a 90 day period of my date of consultation, this fee will be subtracted from the cost of the procedure.

SIGNATURE: _____ DATE: _____

RELATIONSHIP: (circle one) PATIENT SPOUSE PARENT GUARDIAN

MICHAEL C. EDWARDS, MD, FACS, PLASTIC SURGERY
653 N. Town Center Dr., Suite 214 Las Vegas, Nevada 89144
NEW PATIENT REGISTRATION INFORMATION

Patient: _____ Date: _____
Last Name First Name Middle Initial

How do you prefer to be addressed: First name Mr. Mrs. Ms. Miss Doctor Other: _____

Date of Birth: _____ Age: _____ Sex M F Marital Status: M S D W

Social Security Number: _____ E mail address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Employer address: _____ Work phone: _____

RESPONSIBLE PARTY (if patient is a minor): _____

Relationship to patient: Parent Spouse Guardian Other Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer phone: _____

Employer address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION Do you have medical insurance? Y N

Primary insurance: _____ Policy Number: _____

Group name: _____ Group Number: _____

Subscriber's name: _____ Subscriber's date of birth: _____

REASON FOR CONSULTATION: _____

How did you hear about us? Friend _____ Paper Magazine: _____ Radio

In case of emergency, who should be notified? _____ Phone _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

1. I/We hereby consent to examination and/or authorize treatment by Dr. Michael C. Edwards or members of his staff.
2. I authorize the release of any information in the course of my evaluation or treatment to my physicians
3. Each patient, not his/her insurance company, is responsible for payment of all charges to your account at the time services are rendered unless special arrangements are agreed to in advance
4. I authorize insurance benefits be paid directly to Michael C. Edwards, MD. I also authorize Dr. Edwards and his staff to release any information required in the course of my evaluation or treatment to the insurance company.
5. Payments on accounts billed are expected within 30 days.
6. Delinquent accounts will be charged 2% interest per month. I agree to pay any and all collection costs and reasonable attorney's fees if any delinquent balance is placed with a collection agency or attorney for collection or suit.
7. I/We agree to pay all legal fees (court costs, attorney fees, filing fees, commissions) that may be assessed by any agency retained to pursue this matter. I/We agree to pay interest at 1.5%/ month or 18%/year)

Please read and sign below

RESPONSIBLE PARTY: _____ Date: _____

**New Patient Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations**

I, _____, understand that as part of my health care, **Michael C. Edwards, MD, FACS Plastic Surgery** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Michael C. Edwards, MD, FACS Plastic Surgery is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Michael C. Edwards, MD, FACS Plastic Surgery reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Michael C. Edwards, MD, FACS Plastic Surgery change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Patient's Signature

Date

FOR OFFICE USE ONLY

- [] Consent received by _____ on _____.
- [] Consent refused by patient, and treatment refused as permitted.
- [] Consent added to the patient's medical record on _____.

PATIENT CONSENT AND RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to an individual's office instead of the individual's home.

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

- Home Telephone**
 - OK to leave message with **detailed information on home answering machine**
 - Leave message with **call back number only**
 - OK to leave message **with spouse/significant other at home number**
- Work Telephone**
 - OK to leave message with **detailed information**
 - Leave message with **call back number only**
- Written Communication**
 - OK to mail to **my home address**
 - OK to mail to my **work/office address**
- Electronic Communication**
 - OK to communicate with me by email (this may include newsletters)
 - OK to fax to home/office fax number
 - E mail address: _____

It is alright with me to communicate information about me (appt. reminders, updates, test results, etc.) to the following individuals;

| | | |
|------|--------------|--------|
| | | |
| Name | Relationship | Number |

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual. Healthcare entities must keep a record of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record. Note: Uses and disclosures for TPO (Treatment, Payment, or Operations) may be permitted without prior consent for an emergency.

| | |
|-------------------|---------------|
| Patient Signature | Date |
| Patient Name | Date of Birth |

RECORD OF PHI DISCLOSURES
 *****THIS IS FOR OFFICE USE ONLY*****

| Date | Disclosed to whom (address or fax) | Description of purpose of disclosure | By whom disclosed |
|------|------------------------------------|--------------------------------------|-------------------|
| | | | |
| | | | |
| | | | |
| | | | |

PATIENT PHOTOGRAPHIC AUTHORIZATION CONSENT

I consent to the taking of photographs or videotapes of me or parts of my body, by Dr. Michael C. Edwards or his designee. I further consent to the release by Dr. Edwards to the American Society for Aesthetic Plastic Surgery, Inc. (ASAPS) or the American Society of Plastic Surgeons, Inc. (ASPS) of such photographs, videotapes or case histories. I understand that such photographs, videotapes or case histories may be published by Dr. Edwards and/or ASAPS-ASPS and/or any party acting under their license and authority in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, 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 that 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 will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) 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. Edwards.**

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASAPS-ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by ASAPS-ASPS. I release and discharge Dr. Edwards, ASAPS-ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs, videotapes or case histories 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 these materials in any medium.

I recognize that prospective patients, such as me, will ask to look at before and after photographs in the process of choosing a surgeon and evaluating specific procedures. *I authorize* the anonymous use of my photographs for this purpose by Dr. Edwards.

Yes No

I authorize the anonymous use of my photographs by Dr. Edwards in seminars, health fairs and conferences for interested and/or prospective patients. Yes No

I authorize the anonymous use of my photographs in articles written by Dr. Michael C. Edwards for publication in medical journals so long as I am notified in writing of such use prior to publication. Yes No

I authorize the anonymous use of my photographs in articles written by Dr. Edwards for publication on Dr. Edwards web site or in magazines and newspapers so long as I am notified in writing of such use prior to publication. Yes No

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

Date

WITNESS: _____

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.

Patient/Guardian

Date

Michael C. Edwards, MD, FACS Plastic Surgery
653 N. Town Center Drive, Suite 214, Las Vegas, NV 89144
(702) 248-8989; Fax (702) 243-7923