SANTA FE PLASTIC SURGERY CENTER

PATIENT INFORMATION

1631 Hospital Drive, Suite 150 | Santa Fe, NM 87505 | T 505 988 2215 | F 505 984 0373

First Name ______________ Middle Initial __________ Last Name ______________

By what name would you like to be addressed? ______________

Age ______________ Date of Birth ______________ SS# ______________

Mailing Address ______________

City ______________ State __________ Zip ______________

Home Phone ______________ Work Phone ______________ Cell ______________

Email Address ______________ ☐ OK To Email Information

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced

Occupation ______________ Employer ______________

In case of an emergency notify: ______________ Phone ______________

Reason for Visit: ______________

____

Referred by: ☐ Pasatiempo ☐ Phone Book ☐ Internet ☐ Fine Lifestyle ☐ Facebook ☐ Friend/Family ☐ Doctor

Name of Referrer: ______________

Do you have sleep apnea? **Y N** Do you use CPAP? **Y N**

Medications you are allergic to: ______________

____

Medications you are taking: ______________

____

____

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Have you given birth to any children? **Y N** How many? ____________

Have you recently traveled or are you planning a trip? **Y N** Details: ____________

Do you take diet pills? **Y N** Name of Diet Pill ____________

Have you ever had a blood transfusion? **Y N** When ____________

Last Physical Exam Date ____________ Doctor ____________

Results of Exam: ____________

____

Dates of: Last Chest X-Ray ____________ EKG ____________ Tetanus Shot ____________

Are you currently having an evaluation for heart, lung, kidney or blood difficulties? **Y N** ____________

____

Have You Ever Had:

- ☐ Rheumatic Fever/Heart Disease
- ☐ Anemia
- ☐ Jaundice
- ☐ High Blood Pressure
- ☐ Nervous Breakdown
- ☐ Frequent Headaches
- ☐ Seizures
- ☐ Still Birth
- ☐ Fever Blisters

Have Any Problems With:

- ☐ Eyes
- ☐ Heart
- ☐ Lungs
- ☐ Stomach or Bowels
- ☐ Urinary Tract
- ☐ Menstrual Periods
- ☐ Abnormal Bleeding
- ☐ Pain Syndrome
- ☐ Deep Venous Thrombosis

List Any Previous Surgery: ____________

____

List Any Injuries, Illness And Hospitalization: ____________

____

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Do you take :	**Never**	**Sometimes**	**Frequently**	**Daily**
Vitamins	☐	☐	☐	☐
Sedatives	☐	☐	☐	☐
Sleeping pills	☐	☐	☐	☐
Cortisone	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐
Aspirin	☐	☐	☐	☐
Tylenol/Advil	☐	☐	☐	☐

Height ______________________

Weight ______________________

Do you use tobacco? **Y N** How much? ______________________

If you have ever used tobacco, when was the last time? ______________________

Do you use alcohol? **Y N** How much? ______________________

Do you use street drugs? **Y N** How much? ______________________

Has any blood relative ever had diabetes, a nervous disorder, heart attack, cancer, high blood pressure, blood clots, stroke or bleeding disorder? ______________________

Have there been any unexplained deaths or complications arising from anesthesia (including dental office) with any family members? ______________________

Is there a personal history of a muscle disorder (e.g. muscle weakness)? **Y N** ______________________

Payment Information

We appreciate having you as a patient. We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Payment in full is expected at the time of service. We accept cash, checks, Visa or Mastercard. We will make every effort to work with you if a payment plan must be implemented. Delinquent accounts over 90 days will be turned over for collection if no attempt to communicate with this office has been made.

Signature ______________________ **Date** ______________________

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PATIENT RECORD OF DISCLOSURE

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In general, the HIPAA 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 be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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

HOME 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 ☐ OK to fax to this number

WORK TELEPHONE ____________________

☐ OK to leave message with detailed information ☐ Leave message with call-back number only

E-Mail Address ____________________ ☐ OK to email information

____________________	____________________	____________________
Patient Signature	Print Name	Date

The Privacy Rule generally requires healthcare providers to take responsible steps to limit the use or disclosure 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 requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided above, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

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NOTICE OF PRIVACY PRACTICES

1631 Hospital Drive, Suite 150 | Santa Fe, NM 87505 | T 505 988 2215 | F 505 984 0373

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: Treatment, Payment and Health Care Operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION, WHICH YOU CAN EXERCISE BY PRESENTING A WRITTEN REQUEST TO THE PRIVACY OFFICER:

- The right to request restrictions on certain use and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to ammend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of March 1, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. Complaints about this Notice of Privacy Practices or how Santa Fe Plastic Surgery handles your health information should be directed to: **Rachel Trujillo (505) 988-2215.**

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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I acknowledge that I have been given a copy of the Santa Fe Plastic Surgery Notice of Privacy Practices.

____

Printed Name of Patient

____

Patient Signature

____

Date