Board Certified Plastic Surgeon

USHA RAJAGOPAL, M.D.

San Francisco Plastic Surgery
& Laser Center, *A Medical Corporation*

PATIENT INFORMATION SHEET

Name:____ **Today's Date:** __________

Age:________ DOB:_______________ Marital Status: S M W D

Address:_____________________________________ City:_____________ ZIP:_________________

Email address: ____

Would you like to be notified of specials and promotions? yes no

Please list phone numbers that we may leave a private message on:

Phone (H W C)________________________ Phone (H W C)_________________________________

Employer:____________________________________ Occupation:____________________________

Business Address:_________________________________ City:____________ ZIP:______________

Emergency Contact (name/phone):____

How did you hear about our office:

INTERNET (list search engine) _______________________________

GOOGLE LOCAL YELP REALSELF.COM OTHER: ___________________________________

DOCTOR REFERRAL FRIEND PAST PATIENT (list name) __________________________

FOR SKIN or LASER TREATMENTS ONLY

Please circle any of the following that apply:

Currently Using: Accutane / Retin A / Renova / Glycolic Acid / Hydroquinone / **History of**: abnormal scarring history or change in skin pigmentation history / skin infections / herpes simplex or cold sores / allergies to medication / prone to Hypo or Hyper-pigmentation / folliculitis /any sun sensitivity or photosensitivity / ever had facial surgery or any laser procedure
Are You Currently: suntanned or currently sunburned / taking any medication / **none of the above**
Special Concerns / Requests: ____

Acknowledgement of Receipt of Notice of Privacy Practices:
I read and understand this office's Notice of Privacy Practices.

Signature:____________________________________ **Date:**__________________

PRIMARY REASON FOR VISIT:

____

Would you like a complimentary skin consultation: ☐ yes ☐ no

PLEASE CHECK ALL THAT MAY APPLY

FACE

☐ Face Lift
☐ Brow Lift
☐ Blepharoplasty (Eyes)
☐ Cheek Lift
☐ Chin Implant
☐ Ear Reduction/Ear Tuck
☐ Buccal Fat Removal
☐ Botox for Facial slimming

BREAST

☐ Breast Augmentation
☐ Breast Lift
☐ Breast Reduction
☐ Inverted Nipple
☐ Areola Reduction

BODY

☐ Liposuction
☐ Thigh Lift
☐ Arm lift
☐ Body Lift
☐ Abdominoplasty (Tummy Tuck)
☐ Gynecomastia (Male BreastReduction)
☐ Labiaplasty
☐ Ankle/Calf Liposuction
☐ Brazilian Butt Lift
☐ CoolSculpting
☐ FemiLift

NOSE

☐ Rhinoplasty
☐ Obstructed Nasal Breathing
☐ Septoplasty (correction of deviated septum)
☐ Sinus surgery
☐ Non-surgical Rhinoplasty

MEDICAL SKIN CARE

☐ Botox
☐ BellaFill
☐ Kybella
☐ Juvederm
☐ Restylane/Perlane
☐ PRP for Hair Growth
☐ Radiesse/Belotero
☐ Sculptra
☐ Volbella
☐ Lip Augmentation
☐ Infini RF
☐ Sclerotherapy
☐ Skin Peels
☐ Sculptra
☐ Obagi Nu-Derm
☐ Skin Care Products

LASER

☐ Hair Removal
☐ Tattoo Removal
☐ Photofacial
☐ Spider Vein
☐ Mole removal
☐ Age Spots
☐ Acne & Scars
☐ Broken Capillaries/Rosacea
☐ Laser Skin Resurfacing
☐ Dermabrasion
☐ Freckle/Brown Spot Removal

OTHER CONCERNS

____

MEDICAL HISTORY & AUTHORIZATION FOR EXAMINATION

Patient Name: ___________________________Age_____ Height______Weight ______

Please circle or list all medications, which you are currently taking or have taken in the past 6 months. Birth control pills, aspirin or ibuprofen containing drugs, diet pills, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, Nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, sleeping pills, anti-depressants, pain pills or shots, epilepsy medications. **Please include amount taken and frequency:**
____
____

Drug allergies: ____ ___________
Have you ever used (circle): LSD/speed/cocaine/marijuana? Never
Are you a smoker? YES/NO Ex-smoker YES/NO Nonsmoker YES/NO
How much are (were) you smoking?______ How long?_____ Quit how along ago?________ **How much alcohol do you drink?________ Caffeine?___________**

Please circle all of the following medical conditions you now have or have had in the past: / HIV / Bleeding tendency / hepatitis / diabetes / blood transfusion / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / any other serious illness or injury / none of the above.

Is there any possibility that you may be pregnant at this time? YES/NO
List all surgeries that you have had in the past (include plastic surgery):_______
____
____

Have you or anyone in your family had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems, or unexpected fevers)? YES/NO

Do you have (circle): loose or chipped teeth /caps/Veneers/dentures /contact lenses/none
Have you ever seen a cardiologist? YES/NO, Physicians Name:______Date of last EKG:__

I,_________ _____________________, represent to the physicians and staff that I am at least 18 years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor 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 from treatment, I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize that taking of photographs at the direction of my surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential.

Signature: ___________________________ **Date:** ____________

Usha Rajagopal, M.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10/1/02 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for addition- al copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reason- able inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that -you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circum- stances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies. we will charge you $0.25 for each page, $20 per hour for staff time to locate and copy your health information. and postage if you want the copies mailed to you. If you request an alternative format; we will. charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before Apri114. 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under ~ the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing. and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement of Receipt of Notice of Privacy Practices:
I read and understand this office's Notice of Privacy Practices.

Signature:______________________________ **Date:**_______________