



SURGICAL ARTISTRY INC.
PATIENT HEALTH HISTORY
 Dr. Tammy Wu, Board Certified Plastic Surgeon
 Dr. Calvin Lee, Board Certified General Surgeon



REGISTRATION FORM

Today's Date:				Primary Care Physician:			
PATIENT INFORMATION							
Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	
Number Of Children:	Birth Date: / /	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	E-Mail Address:			
Social Security No.:		Cell Phone No: ()	Leave A Message <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Phone No.:	Leave A Message <input type="checkbox"/> Yes <input type="checkbox"/> No		
Street Address:		City:		State:	ZIP Code:		
Occupation:		Employer:			Employer Phone No.: ()		
Referred To Clinic By (Please Check One Box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	<input type="checkbox"/> Family
<input type="checkbox"/> Friend	<input type="checkbox"/> Close To Home/Work	<input type="checkbox"/> Internet	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other Family Members Seen Here:							
INSURANCE INFORMATION							
(Please Give Your Insurance Card And Photo I.D To The Receptionist.)							
Person Responsible For Bill:		Birth Date: / /	Address (If Different):			Home Phone No.: ()	
Is This Person A Patient Here?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer Address:				Employer Phone No.: ()	
Please Indicate Primary Insurance							
Subscriber's Name:		Subscriber's S.S. No.:	Birth Date: / /	Group No.:	Policy No.:	Co-Payment: \$	
Patient's Relationship To Subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
IN CASE OF EMERGENCY							
Name Of Local Friend Or Relative (Not Living At Same Address):				Relationship To Patient:	Home Phone No.:	Work Phone No.:	
					()	()	
In The Case Of An Emergency, My We Release Information To This Person?				<input type="checkbox"/> Yes <input type="checkbox"/> No	Leave A Message	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>The Above Information Is True To The Best Of My Knowledge. I Authorize My Insurance Benefits Be Paid Directly To The Physician. I Understand That I Am Financially Responsible For Any Balance. I Also Authorize Surgical Artistry Or Insurance Company To Release Any Information Required To Process My Claims.</i>							
_____ Patient/Guardian Signature				_____ Date			
_____ Witness Signature				_____ Date			



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Dr. Calvin Lee, Board Certified General Surgeon



Patient Name: _____ **Age** _____
(Last) (First) (MI)

Primary Care Doctor: _____

Reason For Seeing The Dr. Today: _____

List Any Medications You Are Taking, Including Non-Prescription, Vitamins And Herbs: _____

Drug Allergies And Reactions: _____

List Previous Surgeries Or Major Illnesses Including Dates: _____

Social History: Smoking (Type & Amount Per Day) _____ Date Quit: _____
Alcohol (Type And Amount Per Week) _____ Any drug History: _____
Weight _____ Height _____ Bra Size (For breast consultations): _____

Family History: (Relatives)

	Yes	No	Who?		Yes	No	Who?
Breast Cancer				Heart Disease			
Melanoma				High Blood Pressure			
Stroke				Depression			
Diabetes				Kidney Disease			

Past Medical History: (You)

	Yes	No		Yes	No		Yes	No
Heart Disease			Glaucoma			Stomach Ulcer		
Arthritis			Rheumatic Fever			Kidney Disease		
Cancer			Asthma			Thyroid Disorder		
Anemia			AIDS Or HIV+			Bleeding Tendency		
Tuberculosis			Stroke			Mitral Valve Prolapse		
Diabetes			Hepatitis			High Blood Pressure		

Review Of Symptoms: Do You Presently Have, Or Had Within The Past Year:

	Yes	No		Yes	No		Yes	No
Weight Changes			Sleep Apnea			Seizures		
Dry Eyes			Swollen Feet/Ankles			Joint/Muscle Pain		
Chronic Cough			Skin Rash			Swollen Lymph Nodes		
Bloody Stool			Chronic Diarrhea			Easy Bleeding		
Chest Pain			Jaundice			Easy Bruising		
Rapid Heart Beat			Depression			Fever Blisters		

Women Only: For All Breast Consultations

	Yes	No	Have You Had/Or Plan To Have Any:	Yes	No	Date
Do You Do Regular Breast Self-Examinations?			Chemotherapy			
Have You Had Breast Lump Or Discharge?			Radiation			
Do You Breast Feed?			Last Mammogram			

I Verify That The Above Information Is True To The Best Of My Knowledge.

X _____
Signature Of Patient Or Parent If Minor

Date

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Calvin Lee, MD General Surgeon, Acupuncturist

PRIVACY POLICIES

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will--

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws And current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will--
 - ✓ Implement' reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will--
 - ✓ Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
 - ✓ Not disclose PHI data unless the patient (or his/her authorized representative) has properly authorized the release or the release is otherwise authorized by law.
 - ✓ Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will--
 - ✓ Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.

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- ✓ Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.
- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

Surgical Artistry Inc.
2336 Sylvan Ave, Suite C
Modesto, CA 95355
Phone (209) 551-1888
Fax (209) 551-5662
www.surgerytoday.com

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Calvin Lee, MD General Surgeon, Acupuncturist

**RECEIPT OF NOTICE OF PRIVACY POLICIES
WRITTEN ACKNOWLEDGEMENT FORM.**

I, _____ have received a copy of Surgical Artistry Inc.'s
Patient's name

Notice of Privacy Practices.

Signature of Patient

Date

Signature of Witness

Date

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Consent for Photographs or Digital Imaging

In Connection with, and in consideration of medical services for which I have been receiving, or am about to receive from Tammy Wu, MD and/or Calvin Lee, MD; I hereby consent that clinical photographs or digital imaging may be taken of me, or parts of my body, under the following conditions:

- The photographs/digital imaging shall be taken only with the consent of my physician and under such conditions and at such times as may be approved by him/her.
- The photographs/digital imaging shall be taken by my physician or by a photographer approved by my physician.
- The photographs/digital imaging shall be used for medical record purposes and shall remain the property of Tammy Wu, MD and Calvin Lee, MD.

Series of Pictures Pertaining To:

Signature of Patient/Personal Representative

Date

Witnessed By:

Date

Smoking, Second-Hand Smoke Exposure, Nicotine Products (Patch, Gum, Nasal Spray):

Patients who are currently smoking, use tobacco products, or nicotine products (patch, gum, or nasal spray) are at a greater risk for significant surgical complications of skin dying, delayed healing, and additional scarring. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smokers may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication. Please indicate your current status regarding these items below:

- I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.
- I am a smoker or use tobacco / nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

It is important to refrain from smoking at least 6 weeks before surgery and until your physician states it is safe to return, if desired.

Patient Signature

Date

Witness

Date



Veins • Acupuncture • Plastic Surgery

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I _____ give my permission to discuss my medical diagnosis, treatment, test results and appointments with:

- Anyone in my family
- Only the following people

1. Name _____

Relationship _____

2. Name _____

Relationship _____

3. Name _____

Relationship _____

- Please **do not** release any information to anyone

In case of emergency I give my permission for all employees of Surgical Artistry Inc. to speak to _____.

Relationship _____ Phone number () _____

Patient Name _____

Date _____

Patient Signature _____

Date _____

Witness _____

Date _____

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NOTICE OF FINANCIAL RESPONSIBILITY

I, _____, understand that I will have services rendered by Dr. Tammy Wu / Dr. Calvin Lee. The above services may have been pre-authorized by my insurance company. However, I understand that the pre-authorization does not constitute a guarantee of payment for the pre-authorized services. Therefore, if the insurance company should deem the services and or surgery/surgeries medically unnecessary and deny payment after the services have been rendered, I will take full responsibility for payment of the services.

I have read the above paragraph and understand my financial responsibilities as outlined above.

Name of Patient

Date

Witness

Date

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