Thank you for scheduling your consultation with Eugene D. Elliott, M.D. We would like to make your time with Dr. Elliott as productive and informative as possible therefore we are requesting the following:

**APPOINTMENT CONFIRMATION**

Our office will need to reach you by phone to confirm the time and location of your visit. If you miss our phone call, please contact our office at 714-241-0646 to confirm. You may leave your confirmation with our office or answering service if necessary. Unfortunately, if we cannot confirm your appointment, your appointment will have to be rescheduled.

**BRING COMPLETED PAPERWORK WITH YOU TO YOUR CONSULTATION.**

**SMALL CHILDREN:**

Your consultation time with Dr. Elliott has been reserved especially for you, and will include an exam of the area or areas of your concern. Dr. Elliott will answer any questions you might have, and you will be given a quote for the procedure/procedures that were discussed.

If you have any questions regarding your appointment, please don’t hesitate to call one of our staff at 714-241-0646.

**WE LOOK FORWARD TO MEETING YOU.**
Eugene D. Elliott, M.D., F.A.C.S.
Cosmetic and Reconstructive Plastic Surgery
Diplomate American Board of Plastic and Reconstructive Surgery
Member American Society Aesthetic Plastic Surgeons

HISTORY AND PHYSICAL
PLEASE COMPLETE ALL AREAS!

PATIENT INFORMATION

Patient Name: ___________________________ Today's Date: ____________
Date of Birth: ___________ Age: ______ Height: _______ Weight: _______ Male / Female
Address:________________________________________ Apt#__________
City_________________________ State______ Zip Code_______________

Home Phone: __________________________ Ok to Contact? Yes or No (Please Circle)
Work Phone: __________________________ Ok to Contact? Yes or No (Please Circle)
Cell Phone: __________________________ Ok to Contact? Yes or No (Please Circle)
E-Mail Address: _______________________ Ok to Contact? Yes or No (Please Circle)

Place of Employment: __________________ Occupation: _______________________
Social Security #: _____________________ Primary Care Physician: _______________
Pharmacy Name: ______________________ Pharmacy Ph#: ________________

In case of emergency contact: Name: ____________________________
Phone: ___________________________ Relationship to patient: _______________________

Whom may we thank for referring you? ____________________________
Marital Status: Married Single Divorced Widowed

INSURANCE INFORMATION:
Is your insurance an: HMO / PPO / POS?
Name of Insurance Co: ______________________ If an HMO, for which group: ______________
Responsible party: _________________________
Phone: _________________________________
Date of Birth: ___________ Age: _______ Relationship to patient: _________________
Social Security Number: ______________________
Address (If different than patient's):
City: ___________________________ State: ___________ Zip: _______________
Employer: ___________________________ Phone Number: ________________
**LIST PREVIOUS SURGERIES:**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Year</th>
<th>Complications</th>
<th>Type of Anesthesia</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**ALLERGIES AND ALLERGIC REACTIONS TO MEDICATIONS:**


**MEDICATIONS YOU ARE TAKING NOW:**

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose / How often</th>
<th>Reason for taking:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**VITAMINS AND HERBAL REMEDIES YOU ARE TAKING NOW:**

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose / How often</th>
<th>Reason for taking:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>
PLEASE ANSWER ALL QUESTIONS BELOW:

Yes  No
— Do you use Aspirin or medications containing Aspirin?
— Do you use Blood Thinners, (i.e. Coumadin, Heparin, Aspirin, or Ibuprofen)? If yes, name of medication used:
— Have you used diet pills in the last 2 weeks? If yes, which one:
— Have you taken steroids in the last year? If yes, which one:
— Have you ever smoked? If yes, # of packs per day_____ # of years: ______ if you quit, when:__________?
— Do you drink alcohol? If yes, how much:_____________ How often:________________
— Do you use recreational drugs? If yes, type:_________________________ How often:_____________?
— Have you or your immediate family had unusual reactions, problems or complications associated with anesthesia? If yes, describe:
— Do you or your family have malignant hyperthermia?
— Do you exercise? If yes, how often:_____________ How long:_____________
— Is your level of activity related to health limitations? If yes, explain:
— Do you have caps, bridges, dentures, loose teeth? If yes, explain:
— Do you have dry eyes?
— Do you use herbal medications, such as: St john's wart, Ginkogobiloba, Ginseng, Garlic, Echineca etc.?
— Do you have a history of breast cancer?
— Do you have a history of bleeding disorders?
— Do you have a history of autoimmune or connective tissue disorder?
— Have you ever been treated/diagnosed for psychiatric disorders?

FAMILY HISTORY:

Yes  No
— Do you have a family history of breast cancer? Which family member?
— Do you have a family history of bleeding disorders? Which family member?
— Do you have a family history of autoimmune or connective tissue disorder? Which family member?
**MEDICAL HISTORY:** Have you ever had any of the following? Check all that apply.

<table>
<thead>
<tr>
<th>Yes No</th>
<th>Yes No</th>
<th>Yes No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack</td>
<td>Asthma</td>
<td>Artificial Joint</td>
</tr>
</tbody>
</table>
| Coronary Artery Disease | Prothesis | Which Joint?
| Angina, Chest Pain | Sleep Apnea | Neck Pain |
| Shortness of breath w/Exertion | Snoring | Back Pain |
| walking 2 flights of stairs | Emphysema | Implanted defibrillator |
| Bronchitis | Congestive heart Failure | |

<table>
<thead>
<tr>
<th>Yes No</th>
<th>Yes No</th>
<th>Yes No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor circulation</td>
<td>Blood clot in lung</td>
<td>Abnormal past EKG</td>
</tr>
<tr>
<td>Neck</td>
<td>Diabetes</td>
<td>Pacemaker</td>
</tr>
<tr>
<td>Legs</td>
<td>Hyperthyroidism</td>
<td>Bleeding Disorder</td>
</tr>
<tr>
<td>Abnormal sensations w/Exertion</td>
<td>Hypothyroidism</td>
<td>Easy Bruising</td>
</tr>
<tr>
<td></td>
<td>Hypoglycemia</td>
<td>Frequent nosebleeds</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes No</th>
<th>Yes No</th>
<th>Yes No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Pain</td>
<td>High Cholesterol</td>
<td>Anemia</td>
</tr>
<tr>
<td>Arms Pain</td>
<td>Blood in Urine</td>
<td>Heartburn</td>
</tr>
<tr>
<td>Neck Pain</td>
<td>Painful Urination</td>
<td>Hiatal hernia</td>
</tr>
<tr>
<td></td>
<td>Dialysis</td>
<td>Ulcers</td>
</tr>
<tr>
<td>Irregular heart rate</td>
<td>Kidney stones</td>
<td>Change in bowel habits</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Urinary infection</td>
<td>Irritable Bowel</td>
</tr>
<tr>
<td>Heart murmur</td>
<td>Myasthenia Gravis</td>
<td>Bleeding w/bowel movement</td>
</tr>
<tr>
<td>Heart valve problems</td>
<td>Paralysis</td>
<td>Blood transfusion Date:</td>
</tr>
<tr>
<td>Swelling feet/ankles</td>
<td>Arthritis</td>
<td>Motion Sickness</td>
</tr>
<tr>
<td>Breast Disease</td>
<td>Stroke</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>Prostate Disease</td>
<td>Seizures</td>
<td></td>
</tr>
<tr>
<td>Cancer/Malignancy</td>
<td>Headaches</td>
<td>Do you have any specific needs?</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Fainting</td>
<td>Hearing</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Weakness</td>
<td>Vision</td>
</tr>
</tbody>
</table>

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If Female, is there a possibility of being pregnant? When was your last menstrual period?__________
LIST ANY MEDICAL CONDITIONS NOT LISTED ABOVE

As a courtesy, our office will make every attempt to collect insurance benefits in regard to your care with Dr. Elliott, however, it has come to our attention that more insurance companies are now denying claims they have previously authorized. We therefore are obliged to inform you that you are ultimately responsible for any bills incurred with Dr. Elliott.

A. AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I authorize payment directly to the undersigned physician of any surgical and / or medical benefits, if any otherwise, payable to me for his services.

B. AUTHORIZATION TO RELEASE MEDICAL INFORMATION:
I hereby authorize the undersigned physician to release any information acquired during the course of my examination and treatment.

To the best of my knowledge, the information contained in the above history and physical is complete, true and correct.

Patient Signature______________________________________________
Date______________________________
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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

continued on next page
<table>
<thead>
<tr>
<th>Your Rights continued</th>
</tr>
</thead>
</table>

**Ask us to limit what we use or share**
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
  - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we’ve shared information**
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.
Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

<table>
<thead>
<tr>
<th>Treat you</th>
<th>We can use your health information and share it with other professionals who are treating you.</th>
<th>Example: A doctor treating you for an injury asks another doctor about your overall health condition.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Run our organization</td>
<td>We can use and share your health information to run our practice, improve your care, and contact you when necessary.</td>
<td>Example: We use health information about you to manage your treatment and services.</td>
</tr>
<tr>
<td>Bill for your services</td>
<td>We can use and share your health information to bill and get payment from health plans or other entities.</td>
<td>Example: We give information about you to your health insurance plan so it will pay for your services.</td>
</tr>
</tbody>
</table>

continued on next page
How else can we use or share your health information? We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

| Help with public health and safety issues | We can share health information about you for certain situations such as:  
|  | • Preventing disease  
|  | • Helping with product recalls  
|  | • Reporting adverse reactions to medications  
|  | • Reporting suspected abuse, neglect, or domestic violence  
|  | • Preventing or reducing a serious threat to anyone’s health or safety |

| Do research | We can use or share your information for health research. |

| Comply with the law | We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law. |

| Respond to organ and tissue donation requests | We can share health information about you with organ procurement organizations. |

| Work with a medical examiner or funeral director | We can share health information with a coroner, medical examiner, or funeral director when an individual dies. |

| Address workers’ compensation, law enforcement, and other government requests | We can use or share health information about you:  
|  | • For workers’ compensation claims  
|  | • For law enforcement purposes or with a law enforcement official  
|  | • With health oversight agencies for activities authorized by law  
|  | • For special government functions such as military, national security, and presidential protective services |

| Respond to lawsuits and legal actions | We can share health information about you in response to a court or administrative order, or in response to a subpoena. |
Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

09/23/2013

This Notice of Privacy Practices applies to the following organizations.

Eugene D. Elliott, M.D., Inc., F.A.C.S.
Cosmetic and Reconstructive Plastic Surgery
Diplomate American Board of Plastic and Reconstructive Surgery
Member American Society of Aesthetic Plastic Surgeons
1441 Avocado Ave., Suite 730
Newport Beach, CA 92660
(949) 718-0650, Fax (949) 718-0848
9903 Talbert Ave., Suite 101
Fountain Valley, CA 92708
(714) 241-0646, Fax (714) 241-9029
www.eugeneelliott.com
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing this form you acknowledge you were advised of the Notice of Privacy Practices for Eugene D. Elliott, M.D. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. The Notice of Privacy is available on our website at www.dreugeneelliott.com and in our office. You may request a copy of the Notice of Privacy.

_________________________  ________________________________
Signature of Patient/Patient Representative  Date

_________________________  ________________________________
Name of Patient/Patient Representative (please print)  Relationship to Patient

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL RECORDS

PATIENT NAME:

_________________________  _____________________________  _____________________________  ________________________________
(last)  (first)  (MI)  (other name)

Date of Birth _____ - _____ - _____  Phone____________________

Address______________________________City_______________State________

Zip code_______________

I authorize disclosure of my protected health information to the following:

NAME______________________________RELATIONSHIP____________________________
NAME______________________RELATIONSHIP____________________________

NAME______________________RELATIONSHIP_____________________________

THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL IT IS REVOKED BY
A REQUEST IN WRITING. YOU HAVE THE RIGHT TO RECEIVE A COPY OF
THIS AUTHORIZATION.

SIGNATURE OF PATIENT                                                               DATE

PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON                                          DATE