

**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:**

Procedure	Year	Complications	Type of Anesthesia
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**ALLERGIES AND ALLERGIC REACTIONS TO MEDICATIONS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS YOU ARE TAKING NOW:**

Name of Medication	Dose / How often	Reason for taking:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Name of Medication	Dose / How often	Reason for taking:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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.**

Yes No

- Heart Attack
- Coronary Artery Disease
- Angina, Chest Pain
- Shortness of breath w/Exertion
- walking 2 flights of stairs
- Bronchitis

Yes No

- Asthma
- Prosthesis
- Sleep Apnea
- Snoring
- Emphysema
- Congestive heart Failure

Yes No

- Artificial Joint
- Which Joint? \_\_\_\_\_
- Neck Pain
- Back Pain
- Implanted defibrillator

Yes No

- Poor circulation
- Neck
- Legs
- Abnormal sensations w/Exertion

Yes No

- Blood clot in lung
- Diabetes
- Hyperthyroidism
- Hypothyroidism
- Hypoglycemia

Yes No

- Abnormal past EKG
- Pacemaker
- Bleeding Disorder
- Easy Bruising
- Frequent nosebleeds

Yes No

- Chest Pain
- Arms Pain
- Neck Pain
- Irregular heart rate
- High Blood Pressure
- Heart murmur
- Heart valve problems
- Swelling feet/ankles
- Breast Disease
- Prostate Disease
- Cancer/Malignancy

Yes No

- High Cholesterol
- Blood in Urine
- Painful Urination
- Dialysis
- Kidney stones
- Urinary infection
- Myasthenia Gravis
- Paralysis
- Arthritis
- Stroke
- Seizures
- Headaches
- Fainting
- Weakness
- Numbness

Yes No

- Anemia
- Heartburn
- Hiatal hernia
- Ulcers
- Change in bowel habits
- Irritable Bowel
- Bleeding w/bowel movement
- Blood transfusion Date: \_\_\_\_\_
- Motion Sickness
- Multiple Sclerosis

**Location:** \_\_\_\_\_

- Radiation Therapy
- Chemotherapy

**Do you have any specific needs?**

- Hearing
- Vision
- Living alone
- Transportation

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** \_\_\_\_\_

**Eugene D. Elliott, M.D. Inc., F.A.C.S.**  
**Cosmetic and Reconstructive Cosmetic and Reconstructive Plastic Surgery**  
**Diplomate American Board of Plastic and Reconstructive Surgery**  
**1441 Avocado Ave., Suite 710, Newport Beach, Ca 92660 (949)718-0850**  
**9900 Talbert Ave., Suite 101, Fountain Valley, Ca 92708 (714) 241-0646**  
**www.dreugeneelliott.com**

## **HIPPA NOTICE OF PRIVACY PRACTICES**

**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.**

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information, "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health care services.

**Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students. Licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Director, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You May Revoke This Authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in civil, criminal, or administrative action or proceedings and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practice. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request ,even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information, if we deny your request for ammendment you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of, and provide individual with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Your signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

PRINT NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_