NEWMAN
plastic surgery

PATIENT REGISTRATION

Patient Name: _____
FIRST MI LAST

Address: _____City: _____State: _____ Zip Code: _____

Home Phone: _____Cell: _____ EMAIL: _____

Birthdate: ____ / ____ / _____ Age: _____ Sex: _____ Married: _____ Single: _____

Emergency Contact: _____/ Relationship: _____Phone: _____

Primary Physician: _____ Referring Physician/Patient or Friend: _____

HOW DID YOU HEAR ABOUT US?: _____
Google Search / Social Media / Referral (Friend/Family) / Yelp / Website / Other (please specify)

ARE YOU FOLLOWING US ON SOCIAL MEDIA?: _____
Yes (Please specify) / No / Not yet but plan to

WHICH SOCAL MEDIA PLATFORMS DO YOU USE MOST OFTEN? _____
Instagram / Facebook / TikTok / YouTube / Other (please specify)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
I authorize the release of any medical information necessary for my surgery, including but not limited to: lab results, medical clearances, photographs, etc., in compliance with HIPAA.

Signature:_____ Date: _____

AUTHORIZATION FOR PAYMENT
I authorize payment to Dr. Newman for services rendered and am fully responsible for all charges.

Signature:_____ Date: _____

CONSENT FOR PHOTOGRAPH ***FOR INTERNAL PURPOSES ONLY / NOT FOR INTERNET***

Signature:_____ Date: _____

Board Certified, American Society of Plastic Surgeons
DAVID A. NEWMAN, M.D., F.A.C.S.
Hancock Medical Center • Suite 110 • 25150 Hancock Avenue • Murrieta, California 92562 • (951) 698-3344

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MEDICAL HISTORY

Do you take blood thinners, including aspirin products? ○ NO ○ YES _____

Alcohol? ○ Never ○ YES # of drinks per day _____ # of drinks per week _____

Tobacco? ○ Never ○ YES # of packs/day: _____ # of years: _____ Date last used: _____

Circle all that apply: Nicorette (Gum / Patch) Vape Marijuana Pipes Gummies

Any street drug use? _____ Do you take steroids? ○ NO ○ YES

Do you take diet aids/products? ○ NO ○ YES Name: _____ How often: _____

LIST ALL MEDICATIONS: (Including vitamins, supplements (energy bars, protein shakes), birth control, hormones)

Name	Dose	How Often

What medications are you allergic to and what is the reaction? _____

Any allergies to: Penicillan, Sulfa, Iodine, and/or Latex? _____

Does it take longer than 5 minutes to stop bleeding once cut (shaving, etc.)? _____

Could you be pregnant? ○ NO ○ YES

Have you ever been told you have elevated Blood Pressure reading? ○ NO ○ YES

Please list all surgeries in the past (any problems with anesthesia?):

_____

_____

_____

Please check explain any of the following conditions which you now have or have had in the past:

○ Anemia _____
○ Stroke _____
○ Heart Attack / Chest Pain _____
○ Fainting / Dizziness _____
○ Heart Problems _____
○ Mitral Valve Prolapse (any symptoms now)?_____
○ Palpatations _____
○ Chronic Fatigue or fibromyalgia _____
○ History of blood clots in legs or Pulmonary Embolism _____
○ Family history of blood clots _____
○ Do you have (OR HAD) any risk factors for HIV/AIDS? _____
○ Thyroid Disorders _____
○ Emphysema _____
○ Shortness of breath _____
○ Asthma _____
○ Visual problems _____
○ Dry eyes _____
○ Glaucoma _____
○ Tuberculosis _____
○ Obesity (gastric bypass surgery)_____
○ Kidney problems_____
○ Cancer _____
○ Arthritis / Joint pain _____
○ Back pain _____
○ Ulcers _____
○ Depression / Anxiety _____
○ Headaches _____
○ Seizures / Epilepsy_____
○ Infections _____
○ Stomach problems _____
○ Acid Reflux, Indigestion, Heartburn_____
○ Bleeding problems _____
○ Hysterectomy _____
○ Diabetes _____
○ Sleep Apnea Syndrome _____
○ Skin diseases _____
○ Hepatitis / Jaundice / Liver disease _____

The above information is true and correct. Signature: _____ Date: _____

BREAST & COSMETIC SURGERY CENTER DAVID A. NEWMAN M.D., F.A.C.S,

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____
(Print)

Relationship to Patient(if a minor) _____

Signature: _____ _____ Date: _____

OFFICE USE ONLY

I attempted to obtain patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

_____
_____
_____

25150 Hancock Ave., Suite 110 * Murrieta, Ca. 92562 * Phone: (951) 698-3344

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