COSMETIC SURGERY CENTER
Medical Group, Inc.
Terry J. Perkins, M.D.

BASIC INFORMATION			
Name	Date of Birth	Age	Date Today
	/ /		/ /
Home Address	City	State	Zip Code
Mailing Address (If different from Home)	City	State	Zip Code
Occupation	Employer	Home Phone	
		( )	
E-mail address:		Cell Phone	
SSN:	Driver's License:	( )	
Marital Status: S M D W		Work Phone	
Spouse's Name:		( )	
How would you prefer to be contacted? (Please Circle)		Special Contact Requests?	
Home Work Cell E-mail			
Emergency Contact Name:		Phone ( )	
Reason for you consultation:			

Would you like information about treatment for any of the following? (circle all that apply):

Acne Wrinkles Sun Damage Cellulite Body Bulges Excessive Sweat Unwanted Hair Jowls

Age Spots Redness (Rosacea) Spider Veins Pigment Problems Teeth Whitening Thin Lips

Shape/Size of Nose Eye bags/Excess Skin Face/Neck Laxity Stretch Marks "Weak" Chin/"Flat" Cheeks

How did you hear about us? (please circle and include name or additional info where appropriate)

Friend or Family _____ Santa Barbara Independent Verizon Phonebook Community Phonebook Other Publication_____

Business_____ Website Walk-In Other_____

Authorization for Examination and Treatment

I represent to Dr. Perkins and staff that I am at least 18 years old. I hereby authorize the clinical staff at the Cosmetic Surgery Center and/or Evolutions Medical Spa to take my medical history and perform any necessary examinations. I agree to be financially responsible for any charges incurred at the Cosmetic Surgery Center and/or Evolutions Medical Spa.

I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I also authorize any hospital, physician or any other persons who have attended to or examined me to disclose to Terry J. Perkins, M.D., when requested, all information concerning this illness, injury or medical problem. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature_____ **Date**_____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Signature_____ Date:_____

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the
Medical Board of California

1-800-633-2322
www.mbc.ca.gov

Signed:_____

Date:_____

Witness:_____

I acknowledge receipt of the LIST OF PATIENT RIGHTS I N CALIFORNIA/ LIST OF PATIENT RESPONSIBILITIES TO THE COSMETIC SURGERY CENTER MEDICAL GROUP, INC.

Signed:_____

Date:_____

Witness:_____

LIST OF PATIENT RIGHTS IN CALIFORNIA

IN ACCORDANCE WITH SECTION 70707 OF THE CALIFORNIA HEALTH AND SAFETY CODE, THIS MEDICAL FACILITY HAS ADOPTED THE FOLLOWING LIST OF PATIENT RIGHTS:

1. Patients are cared for without regard to sex, cultural, economic, educational, or religious background or the source of payment for his/her care.
2. Patients will receive considerate and respectful care.
3. Patients should have knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians who will see him/her.
4. Every patient will receive information from his/her physician about the illness, the course of treatment and the prospects for recovery in terms that he/she can understand.
5. Patients will receive as much information about any proposed treatment or procedure he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in each and the name of the person who will carry out the procedure or treatment.
6. Every patient will be encouraged to participate actively in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to refuse treatment.
7. All patients will receive full consideration of privacy concerning the medical care program.. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
8. Every patient can expect confidential treatment of all communications and records pertaining to his/her care and stay in the hospital. His/her written permission shall be obtained before the medical records ca be made available to anyone not directly concerned with his/her care.
9. Patients will receive reasonable responses to any reasonable request he/she may make for services.
10. Patients may leave hospital even against the advice of his/her physician.
11. Patients may expect reasonable continuity of care and to know the time and location of appointments as well as the physician providing the care.
12. Patients will be advised if a physician proposes to engage or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.
13. Patients will be informed by his/her physician or a delegate of continuing health care requirements following discharge from the hospital or medical facility.
14. Patients may examine and receive an explanation of his/her bill regardless of the source of payment.
15. Patients have the right to know which hospital rules and policies apply to his/her conduct as a patient.
16. All patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

LIST OF PATIENT RESPONSIBILITIES TO THE
COSMETIC SURGERY CENTER MEDICAL GROUP, INC.

In an effort to develop and maintain a positive Doctor/Patient/Staff relationship it is our expectation to have all patients:

1) Co-operate fully in their medical care until discharged by Terry J. Perkins, M.D.

2) Give complete and truthful information on all 1st consultation and pre-operative forms.

3) Be respectful of the Doctor and Staff

4) Be respectful of another patient's privacy, whether in the waiting area or back office hallways.

5) Actively participate in discussions and decisions regarding medical or surgical procedures.

6) Notify the Cosmetic Surgery Center of any change of address or phone numbers.

7) Notify the Cosmetic Surgery Center of any change in health status or medications.

8) Arrive on time for appointments.

9) Cancel or reschedule any appointment or surgery in a timely manner so that another patient can be moved into that time slot.

10) Pay fees upon service or in the case of surgical procedures, 1 week prior to surgery.

11) Turn off cell phones while in with the Doctor or Staff.

MEDICAL HISTORY

Name (Please Print) _____ DOB _____ Date _____

Please list all medications you take or have taken in the past six months (including OTC):

Medication	Amount	Frequency
_____	_____	_____
_____	_____	_____

List all ALLERGIES including LATEX: _____

Do you have a pacemaker or internal defibrillator? Yes No

Could you possibly be pregnant at this time? Yes No Are you lactating? Yes No

Have you ever taken Accutane? Yes No If yes, when and for how long? _____

Have you ever had cold sores? Yes No If yes, when was last outbreak? _____

Do you form heavy scars? Yes No Bruise easily? Yes No Heal slowly? Yes No

List any chronic skin problems _____

Are you a vegetarian or do you practice any special kind of diet? Yes No

Are you currently using: (circle all that apply)

Retin-A (tretinoin) Glycolic Acid Vit C or other antioxidants Bleaching agents

What other skin care products are you currently using? _____

Do you consider your skin type to be: (circle all that apply)

Normal Combination Sensitive Rosacea Oily Acne-prone
Photosensitive Allergic Dry Aged Pigmented

Have you had an adverse reaction to topical or local (injected) anesthesia? Yes No

Do you smoke? Yes No If yes, how much per day? _____
Do you drink alcohol? Yes No If yes, how much per day? _____

Please circle all of the following medical conditions you now have or have had in the past:

Bleeding tendency Wheezing Heart attack Lupus Blood transfusions Emphysema Chest pain
Depression Vitiligo (pigment loss in the skin) Bronchitis Epilepsy Mental illness High blood pressure
Stroke Heart burn Irregular heart beat Heart Disease Scleroderma Hepatitis B Hepatitis C
Intestinal ulcers or bleeding Dry Eyes Asthma Porphyria Drug or alcohol addiction Glaucoma
TB HIV Rheumatoid arthritis Lung disease Blood Clots Diabetes Malignant hyperthermia
Any other serious illness, condition, or injury None of the above **Use back to give details of circled items**

Please list any surgeries (including cosmetic) you have had along with the date of surgery:

I acknowledge that I have disclosed my entire medical history and the above is a complete and accurate representation of my medical and psychological history and current status.

Signature _____ **Date** _____