CYNTHIA M. GOODMAN, M.D., INC.

Aesthetic & Reconstructive Plastic Surgery

2200 LARKSPUR LANDING CIRCLE, SUITE 104
LARKSPUR, CA 94939
(415) 925-8555

PATIENT INFORMATION

Name:____
First Middle Last

Address:____
Street

____
City State ZIP

Home Phone: ( )____________________ Business Phone: ( )_________________
Cell Phone: ( )_______________________
May we leave a message at one of the numbers above? ___________________________
E-mail address ___________________________________

Date of Birth:___________________ Social Security #:_______________________

Employer:_____________________________ Occupation:__________________________

Primary Care Physician ____

Responsible party for billing____

Name of Insurance___________________________________

ID#____

How were you referred to this office? Patient_____________ Physician____________________

Hospital_____________ Website ______________Other__________________ .

Procedures of Interest____

Emergency contact:____

Phone ( )________________ Relationship_________________________

Would you like to receive office promotions? ________________________

I hereby authorize Dr. Cynthia M. Goodman to obtain any medical records needed to assist in my treatment and give her permission to bill my insurance for any services rendered and release any medical records needed for that billing process. I understand that any benefits not covered by my insurance remain my responsibility. I further authorize her to take photographs of me and consent to the use of those photos for patient education and information purposes. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature_______________________________________ ***Date***_______________________

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History Intake Form

Name:____Date of Birth:_________________________

Name of Primary Care Physician:____

Date of last exam:__________________________________By Whom:___________________________

Weight:_____________________Height:_______________

Name of psychiatrist:________________________________Last seen:___________________________

Please list all previous surgeries or major illnesses and dates: ___________________________________

____

____

Please list any drug allergies:____

Please list any medications taken regularly (including: aspirin, herbals and vitamins)

____

____

Do you have any bleeding tendencies? ____

Do you smoke, if so, amount per day or date you quit if you are a former smoker: __________________

Do you drink, if so, amount per day: _________________________

Past Medical History **Please check if you have ever had any of the following:**

Mitral Valve Prolapse:___ Cancer: ___ Heart Disease: ___ Stroke: ___ Asthma: ___
Cold Sores: ___ Anemia: ___ Arthritis: ___ High Blood Pressure: ___ Depression: ___
Stomach Ulcer: ___ Diabetes: ___ Schizophrenia: ___ Bipolar Disease: ___ HIV/AIDS: ___
Thyroid ____

Please list any other medical problems: ____

____

Family History Please check if any blood relatives have ever had any of the following:

Breast Cancer: ___ Melanoma: ___ Stroke: ___ High Blood Pressure: __
Heart Disease: ___ Diabetes: ___ Kidney Disease: ___ Depression: ___

If applicable: Date of last mammogram: __________ Any breast lumps or discharge? ___________

Number of pregnancies: _________ Did you breast feed? _____________

I verify that the above information is true and correct to the best of my knowledge.

Signature: ____ ***Date:*** ________________

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Patient Name: ______________________________ Date: ________________________

Birth Date: ________________

REVIEW OF SYSTEMS

Do you currently have any of the following problems?

		If YES, Please explain
1. **Constitutional** (fever, weight loss, other)	☐ Yes ☐ No	
2. **Eyes** (glaucoma, cataract, lazy eye, retina problems, other – please specify)	☐ Yes ☐ No	
3. **Ear / Nose / Mouth / Throat** (hearing loss, sinus problems, sore throat)	☐ Yes ☐ No	
4. **Cardiovascular** (heart problems, chest pain, irregular heart beat)	☐ Yes ☐ No	
5. **Respiratory** (asthma, shortness of breath, wheezing, coughing)	☐ Yes ☐ No	
6. **Gastrointestinal** (heartburn, abdominal pain, diarrhea, vomiting)	☐ Yes ☐ No	
7. **Genitourinary** (urinary problems, blood in urine)	☐ Yes ☐ No	
8. **Integumentary** (skin rashes, excessive dryness)	☐ Yes ☐ No	
9. **Musculoskeletal** (muscle aches, joint pain, swollen joints)	☐ Yes ☐ No	
10. **Neurological** (numbness, weakness, headaches, paralysis)	☐ Yes ☐ No	
11. **Hematologic/Lymphatic** (blood disorders, leukemia)	☐ Yes ☐ No	
12. **Allergic/immunologic** (hay fever, allergies)	☐ Yes ☐ No	
13. **Endocrine** (thyroid problems)	☐ Yes ☐ No	
14. **Psychiatric** (depression, anxiety)	☐ Yes ☐ No	

Additional Comments:

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I verify that the above information is true and correct to the best of my knowledge.

Patient's Signature: ______________________________ ***Date:*** ____________________

The above information has been reviewed with the patient.

Physician's Signature: ______________________________ Date: ____________________

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(415) 925-4082 FAX

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, 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 or condition and related 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 health care 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 or a physician to whom you have been referred to ensure that the third party has the necessary information to 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 to support the business activities of the physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. We may 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 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, FDA requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, 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 64.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object as 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

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, 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 operations. 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 this Notice of Privacy Practices. 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 that it is in your best interest to permit use and disclosure of your protected health information, your information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request 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.

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 Dr. Goodman 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 individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

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

Signature_____________________ Print Name__________________ Date___________