TUAN A. TRAN M.D., M.B.A, F.A.C.S.
Diplomate American Board of Plastic Surgery, Diplomate American Board of Surgery
General Surgery, Reconstructive Surgery, Aesthetic Surgery, Plastic and Hand Surgery

PATIENT INTAKE FORM

PATIENT INFORMATION

Date:_____/_____/_____

☐ Male | ☐ Female

Name: [First]_____[M.I.]_____[Last] _____

Address:_____[Apt.] _____ Age: _____ D.O.B:____/____/____

City:_____State:_____Zip:_____Home Tel: _____

Social Security #:_____Driver's License #:_____Mobile Tel: _____

Marital Status: ☐ Single | ☐ Married | ☐ Other Preferred Language: _____

E-mail: _____

EMPLOYMENT INFORMATION

☐ Full Time | ☐ Part Time | ☐ Student | ☐ Retired | ☐ Other Occupation: _____

Employer/School:_____Work Tel: _____

Work/School Address:_____City:_____State:_____Zip: _____

EMERGENCY CONTACT *(Important)*

Name: [First]_____[Last]_____Phone number: _____

Relationship to Patient:_____

Address:_____City:_____

State:_____Zip: _____

MEDICAL INSURANCE INFORMATION (skip *this part if we have a copy of your Insurance.*)

Primary Insurance Company Name:_____ Telephone: _____

Name of Insured: [First]_____[Last] _____

Policy #:_____Group #:_____Co-pay? ☐ Yes | ☐ No If Yes, Amount: $_____

Secondary Insurance Company Name:_____ Telephone: _____

Name of Insured: [First]_____[Last] _____

Policy #:_____Group #:_____Co-pay? ☐ Yes | ☐ No If Yes, Amount: $_____

I understand that office visit charges are payable on the day service is rendered. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Tuan Tran and myself.

Signature: (Patient, Parent or Guardian)_____Date: _____

10301 Bolsa Ave Ste 101
Westminster, CA 92683
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Fax 714-839-8008
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REFERRAL INFORMATION

Referring Physician/Patient/Source: _____

How did you hear about **Dr. Tuan Tran**? _____

Have you been to our website **[www.tranplastic.com]**? ☐ Yes | ☐ No If yes, was our website helpful? ☐ Yes | ☐ No

If No, please list reason: _____

PROCEDURE INFORMATION

What is the reason for your visit today? *[Check all applicable procedures below]*

FACE	BREAST	BODY	SKIN	HAND
☐ Facelift	☐ Breast Augmentation	☐ Liposuction	☐ Botox Cosmetic	☐ Fracture
☐ Cheek Lift	☐ Breast Lift (Mastopexy)	☐ Tummy Tuck	☐ Facial Fillers	☐ Trigger Fingers
☐ Neck Lift	☐ Breast Revision / Repair	☐ Mommy Makeover	☐ Fat Injections	☐ Numbness
☐ Forehead Lift	☐ Breast Implant Exchange	☐ Body Lift	☐ Radiofrequency Therapy	☐ Ganglion cyst
☐ Thread Facelift	☐ Breast Capsulectomy	☐ Buttock Augmentation	☐ PRP treatments	☐ Arthritis
☐ Facial Fat Transfer	☐ Breast Reduction	☐ Arm Lift (Brachioplasty)	☐ Hand Rejuvenation	☐ Carpal Tunnel Syndrome
☐ Facial Implants	☐ Breast Asymmetry	☐ Thigh Lift	☐ O-shot / P-shot	☐ Wrist Pain
☐ Facial Feminization	Other: _____	☐ Fat Transfer	☐ Cellulite	☐ Tendon Injury
☐ Chin Augmentation		☐ **VIVEVE treatment** (Urinary incontinence)	Other: _____	
☐ Ear Reshaping				
☐ Upper Eyelids			☐ **Skin cancer**	
☐ Lower Eyelids	☐ Penis Enlargement	Other: _____	☐ **Keloid**	
☐ Rhinoplasty	☐ Male Breast Surgery		**Location:** _____	
Other: _____	Other: _____		Other: _____	

Please describe why you are interested in having the procedure(s) listed above: _____

_____

Have you consulted with other physicians about procedure(s) indicated above? ☐ Yes | ☐ No Is this procedure a revision from a previous surgery? ☐ Yes | ☐ No

If Yes, how many previous surgeries? _____

SURGERY SCHEDULING QUESTIONAIRE

To help us understand your particular needs and time preferences for your surgery, please provide us with the following information:

What is your time preference for your Procedure? Within the next: ☐ Month | ☐ 3 Months | ☐ 6 Months | ☐ 1 Year

Does your home or work schedule permit such flexibility whereby you could have your aesthetic surgery done on "short notice", i.e. 10-14 days advance notice for a discount on your fees? ☐ Yes | ☐ No

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HEALTH INFORMATION

PATIENT INFORMATION

Name: [First] _____ [M.I.]_____ [Last] _____ D.O.B ___/___/___

Home Tel: _____ Work Tel: _____ Mobile Tel: _____

Primary Care Physician: _____ Internist: _____ Cardiologist: _____

Age: _____ Weight: _____ Height: _____ B/P: *[Avg. Resting B/P]* _____

PERSONAL MEDICAL HISTORY

Do you have any chronic medical problems? *[Fill in box for those that apply]*

☐ High Blood Pressure	☐ Diabetes	☐ HIV or AIDS
☐ Heart Disease	☐ Kidney Disease	☐ Stroke
☐ Heart Failure	☐ Psychiatric Diagnosis	☐ Hepatitis
☐ Seizures	☐ Bleeding Problems	☐ Emphysema
☐ Heart Attack	☐ Liver Disease	☐ Stomach Problems
☐ Chest Pain	☐ Gastric Reflux	☐ Other: _____
☐ Asthma	☐ Cancer	☐ Other: _____

Is there a personal or family of anesthetic complications or malignant hyperthermia? ☐ Yes | ☐ No

If yes, please explain? _____

FAMILY HISTORY

Do you have a family history of any medical problems? *[Fill in box for those that apply]*
Please indicate Family member(s): _____

☐ High Blood Pressure	☐ Diabetes	☐ HIV or AIDS
☐ Heart Disease	☐ Kidney Disease	☐ Stroke
☐ Heart Failure	☐ Psychiatric Diagnosis	☐ Hepatitis
☐ Seizures	☐ Bleeding Problems	☐ Emphysema
☐ Heart Attack	☐ Liver Disease	☐ Stomach Problems
☐ Chest Pain	☐ Gastric Reflux	☐ Breast Cancer
☐ Asthma	☐ Cancer	☐ Other: _____

Please list all prior Operations:	**Date**	**List any complications:**
1. _____	___/___/___	_____
2. _____	___/___/___	_____
3. _____	___/___/___	_____

Please list all prior Hospitalizations:	**Date**	**List any complications:**
1. _____	___/___/___	_____
2. _____	___/___/___	_____
3. _____	___/___/___	_____

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Please list ALL CURRENT MEDICATIONS (*Name/Strength/ Dosage/Reason*) and/or dietary supplements including:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins, and Herbal Supplements)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PHARMACY: _____

ALLERGIC TO MEDICATIONS? Yes / No
Please list ALL ALLERGIES: (i.e. Shellfish, Latex, Penicillin, etc.) _____

REACTION (*please describe*):_____
SEVERITY: ❑ Mild ❑Moderate ❑Severe

SOCIAL HISTORY

Do you use Aspirin or medications containing Aspirin? ☐ Yes | ☐ No

Do you use Blood Thinners? (i.e. Coumadin, Heparin, Aspirin or Ibuprofen) ☐ Yes | ☐ No

If Yes, medication name: _____

Have you used Diet Pills in the last two (2) weeks? ☐ Yes | ☐ No

If Yes, medication name:_____

Have you taken Steroids / Accutane within the last year? ☐ Yes | ☐ No

If Yes, medication name: _____

Have you ever smoked tobacco/Hookah/Vape products? ☐ Yes | ☐ No

If Yes, # of packs per day:_____# of years: _____

If you quit, when? _____

Do you use Recreational Drugs? ☐ Yes | ☐ No

If Yes, list type: _____

Do you Exercise? ☐ Yes | ☐ No

If Yes, how often:_____How long: _____

Type of Exercise? _____

Is your Level of Activity related to health limitations? ☐ Yes | ☐ No

If Yes, please explain: _____

Do you have caps, bridges, dentures, or loose teeth? ☐ Yes | ☐ No

If Yes, please explain: _____

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REVIEW OF SYSTEMS

Please answer the following ***Yes or No questions to the best of your ability***. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure	☐ Yes | ☐ No
Heart Attack	☐ Yes | ☐ No
Angina/chest pain	☐ Yes | ☐ No
Heart bypass surgery	☐ Yes | ☐ No
Pacemaker	☐ Yes | ☐ No
Heart Failure	☐ Yes | ☐ No
Irregular Heartbeat	☐ Yes | ☐ No
Heart Murmur	☐ Yes | ☐ No

RESPIRATORY

Abnormal Chest X-ray	☐ Yes | ☐ No
Asthma	☐ Yes | ☐ No
Bronchitis	☐ Yes | ☐ No
Emphysema	☐ Yes | ☐ No
Recent Chest Infection	☐ Yes | ☐ No
Shortness of Breath	☐ Yes | ☐ No
Shortness of Breath at night	☐ Yes | ☐ No
Shortness of Breath on exertion	☐ Yes | ☐ No
Cough	☐ Yes | ☐ No
Cough with Sputum	☐ Yes | ☐ No
Sleep Apnea	☐ Yes | ☐ No
Use a C-PAP Machine	☐ Yes | ☐ No

GASTROINTESTINAL

Jaundice	☐ Yes | ☐ No
Gallstone	☐ Yes | ☐ No
Liver Disease (Cirrhosis)	☐ Yes | ☐ No
Hepatitis	☐ Yes | ☐ No
Ulcers	☐ Yes | ☐ No
Hiatal Hernia	☐ Yes | ☐ No
Heartburn	☐ Yes | ☐ No

SKIN

Cancer	☐ Yes | ☐ No
Radiation	☐ Yes | ☐ No
Atypical Skin Lesions	☐ Yes | ☐ No

ENDOCRINE

Diabetes	☐ Yes | ☐ No
Hyperthyroidism	☐ Yes | ☐ No
Hypothyroidism	☐ Yes | ☐ No
Hypoglycemia	☐ Yes | ☐ No
High Cholesterol	☐ Yes | ☐ No

PSYCHIATRIC

Depression	☐ Yes | ☐ No
Anxiety	☐ Yes | ☐ No
Psychiatric Care	☐ Yes | ☐ No
Obsessive Compulsive Disorder	☐ Yes | ☐ No

NEUROLOGICAL

Stroke	☐ Yes | ☐ No
Seizures	☐ Yes | ☐ No
Fainting	☐ Yes | ☐ No
Dizziness	☐ Yes | ☐ No
Headache	☐ Yes | ☐ No
Sciatica	☐ Yes | ☐ No
Herniated disc	☐ Yes | ☐ No
Arthritis	☐ Yes | ☐ No
Rheumatoid	☐ Yes | ☐ No

HEMATOLOGIC/ONCOLOGIC

Bleeding Tendency	☐ Yes | ☐ No
Easy Bruising	☐ Yes | ☐ No
Anemia	☐ Yes | ☐ No
Sickle Cell Disease	☐ Yes | ☐ No
Blood clots in legs	☐ Yes | ☐ No
Blood clots in lungs	☐ Yes | ☐ No
Radiation Therapy	☐ Yes | ☐ No

EYES

Cataracts	☐ Yes | ☐ No
Glaucoma	☐ Yes | ☐ No
Dry Eyes	☐ Yes | ☐ No
Do you wear Contact Lenses?	☐ Yes | ☐ No

Please list any other medical conditions that are **NOT** listedabove: _____

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Have you had blood drawn in the past 3 months?	☐ Yes | ☐ No	If Yes, Location: _____
Have you had an EKG done in the last year?	☐ Yes | ☐ No	If Yes, Location: _____
Have you had a chest x-ray done in the last year?	☐ Yes | ☐ No	If Yes, Location: _____
Have you had a recent Physical Exam?	☐ Yes | ☐ No	If Yes, Doctor's Name: _____
		Doctor's Phone Number: _____

FEMALE QUESTIONNARE *(IF APPLICABLE)*

Female Gynecological History:

Have you had any previous pregnancies? Total pregnancies: _____	☐ Yes | ☐ No	☐ Natural Delivery ☐ C-Section Delivery
Date of pregnancies: _____		
Average weight gain during pregnancy: _____		
Did you breast feed during pregnancy?	☐ Yes | ☐ No	
Do you plan on having any or any more children?	☐ Yes | ☐ No	
Do you suffer from urinary leakage or vaginal looseness	☐ Yes | ☐ No	

Female Breast History:

Previous breast mass, suspicious biopsy, or cancer? Do you have a family history of breast cancer?	☐ Yes | ☐ No	
Have you had a mammogram in the last year? If Yes, date of exam:_____/_____/_____	☐ Yes | ☐ No	Mammogram: ☐ Normal ☐ Abnormal
Current bra size? _____	☐ Yes | ☐ No	

Thank you for providing this important information!

_____	_____	_____/_____/_____
Signature Patient/Parent/Conservator/Guardian (Indicate i*f completed other than Patient)*	Print Name	Date

Comments:

_____

_____

_____

Reviewed by:_____ _____/_____/_____

TUAN TRAN, M.D. Date

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A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than in court. By signing this agreement, you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator, who then select a third, neutral arbitrator. These three arbitrators hear the case.

This agreement helps limit the legal costs for both patients and physicians. It is required by our professional liability insurance. Without arbitration, we are in danger of closing our office. Arbitration agreements between healthcare providers and their patients have long been recognized and approved by the California courts. Arbitration agreements have been used by Kaiser and Cigna for decades. Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. Because most problems begin with communication, we encourage you to ask us any questions about our care.

_____

Signature

_____

Date

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PATIENT INTAKE FORM

1. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
This notice briefly summarizes how we handle your health information, and provides further details of our privacy policies and procedures.

2. How we may use and disclose your health information. We use health information about you for treatment, to get paid for treatment, for administrative purposes and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future uses and disclosures.

3. Your rights. In most cases, you have the right to look at a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information

4. Our legal duty. We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

5. Privacy complaints. If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints please contact: 10301 BOLSA AVE. WESTMINSTER, CA 92683. Phone: (714)839-8000. Please sign and print your name and provide the date below to acknowledge that you have received this Notice of Privacy Practices

Signature: _____ Date:_____

Print Name:_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

_____
Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

By: _____
Print Patient's Name

_____
Print or Stamp Name of Physician, Medical Group or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.

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PHOTOGRAPHIC CONSENT AND RELEASE FORM

I, _____ (please print), grant permission to TRAN PLASTIC SURGERY and affiliates, or anyone authorized by any of them, the irrevocable and unrestricted right to capture and reproduce the photographs and/or video images taken of me for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. The Images (including any photographic negatives) shall be the sole property of TRAN PLASTIC SURGERY. I hereby release, discharge, and agree to hold harmless TRAN PLASTIC SURGERY and its affiliates and their respective representatives, assigns, employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name therewith if it so chooses.

I hereby warrant that I am over eighteen years of age and I have read and understand the foregoing release, authorization, and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____Date: _____

I, _____ (please print), hereby irrevocably consent and authorize the use and reproduction of my images without de-identifying physical features for promotional purposes of TRAN PLASTIC SURGERY. Such use shall include, but not limited to, distributing the images via print, visual and electronic media on TRAN PLASTIC SURGERY website and social media sites, such as Instagram, Facebook, and YouTube, without compensation to me.

I hereby warrant that I am over eighteen years of age and I have read and understand the foregoing release, authorization, and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____Date: _____

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