TRAN PLASTIC SURGERY

General, Reconstructive, Aesthetic, Plastic and Hand surgery

TUAN ANH TRAN, M.D./M.B.A
DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY
DIPLOMATE AMERICAN BOARD OF SURGERY

MEDICAL PATIENT INTAKE FORM

PATIENT INFORMATION

NAME: _____ _____ _____
LAST FIRST MIDDLE

ADDRESS: _____ APT./UNIT/SPACE #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: ____/____/____ SSN: _____

CELL #: (____)_____-_____ HOME #: (____)_____-_____ WORK #: (____)_____-_____

EMAIL: _____@_____._____ ☐ N/A

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER GENDER: ☐ FEMALE ☐ MALE

EMPLOYMENT STATUS: ☐ FULL-TIME ☐ PART-TIME ☐ SELF-EMPLOYED ☐ RETIRED ☐ UNEMPLOYED

EMPLOYER/COMPANY NAME: _____

REFERRED BY: _____ PHONE #: (____)_____-_____

Emergency contact:
Please list the person(s) whom we are authorized to communicate with:
(examples: spouse, boyfriend/girlfriend, children, friends, translator, roommate, etc.)

Name:	Relationship:	Number:
_____	_____	(____)_____-_____

INSURANCE INFORMATION

☐ **Primary Insurance Card Copied**

INSURANCE COMPANY: _____ PHONE:(____)_____-_____

POLICY ID: _____ TYPE OF PLAN: ☐ PPO ☐ POS ☐ EPO ☐ HMO ☐ OTHER

HMO/MEDICAL GROUP NAME: _____ GROUP NUMBER: _____

☐ **Secondary Insurance Card Copied (if applicable)**

INSURANCE COMPANY: _____ PHONE:(____)_____-_____

POLICY ID: _____ TYPE OF PLAN: ☐ PPO ☐ POS ☐ EPO ☐ HMO ☐ OTHER

HMO/MEDICAL GROUP NAME: _____ GROUP NUMBER: _____

10301 Bolsa Ave Ste 101
Westminster, CA 92683

Phone 714-839-8000
Fax 714-839-8008

Email graphsurgery@gmail.com
Website www.tranplastic.com

Please read thoroughly, initial, sign, and date.

Insurance Policy:
As a courtesy to you, we will submit to most insurance carriers if you have provided us with policy numbers, address, place of employment and any other pertinent information. Insurance provides for your reimbursement on allowed medical charges. **You are responsible for all deductibles, co-insurance and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility. We will be happy to provide an itemized statement you may send to your insurance company for payment.

I hereby authorize payment of medical benefits from my insurance directly to, Tuan A. Tran, M.D., for any services provided. I understand that I may be financially responsible for charges not covered by insurance.

Initials: _____

Office Policy on Payment:
It is our policy to require payment of all office charges at the time of service, unless prior arrangements have been specifically made. All co-pay responsibilities are to be paid upon arrival/check-in process prior to your visit.

Initials: _____

Authorization to Release Medical Records:
I hereby authorize the office of, Tuan A. Tran, M.D., to disclose any and all information with respect to any illness(es), injury(ies), medical history, and/or treatment and copies of all medical records when requested by my insurance carrier(s) and/or its representatives. (This is needed for processes such as authorization requests, pre-certification, billing and displaying proof of medical necessity for requested services.)

Initials: _____

Consent to Examination

I,_____, hereby authorize, Tuan A. Tran, M.D., to perform a consultation,
(please print name)

diagnostic testing and/or injections, procedures as necessary to treat my condition.

Patient/Guardian Signature:_____**Date:** _____

Patient Health Information

(Please complete the entire form)

What is the reason for this visit?: _____

How long have you had this problem? :_____ ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ Not sure

Have you had testing for this problem? ☐ Yes or ☐ No If yes, where/when? _____

Preferred Pharmacy (required): _____

Address:_____ City:_____ State: _____

Phone: (_____)_____-_____ Height:_____feet_____inches Weight:_____pounds

Medications: List **ALL** medications taken regularly. ☐ See attached list ☐ N/A

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies: **List any allergies and reactions.** ☐ No known drug allergies

_____

Have you ever had difficulties with? ☐ Local Anesthesia ☐ General Anesthesia ☐ N/A

If yes, what was your reaction: _____

Illnesses: (✓ for "YES" or "NO")

	YES	NO		YES	NO
Heart Problems	____	____	High Cholesterol	____	____
Lung Disease	____	____	High Blood Pressure	____	____
Kidney Disease	____	____	Diabetes	____	____
Thyroid Problems	____	____	Epilepsy	____	____
Bleeding Problems	____	____	Gastrointestinal Problems	____	____
Ashma	____	____	Sleep Apnea	____	____
Cancer	____	____	Snoring	____	____
If "yes" give type (location):			Other Medical Conditions	____	____
_____			Specify: _____		

Primary Care Physician: _____ **Cardiologist:** _____

Surgical History: List all surgeries you have had. ☐ N/A

_____

_____

Family Medical History: List any known illnesses/medical conditions. ☐ Unknown

_____

Print Legal Name: _____ **D.O.B.:**____/____/____

Signature: _____ **Date:** _____

SOCIAL HISTORY

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

If Yes, medication name: _____

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

If Yes, medication name: _____

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

If Yes, medication name: _____

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

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

If you quit, when? _____

5. Do you use Recreational Drugs? ☐ Yes | ☐ No

If Yes, list type: _____

6. Do you Exercise? ☐ Yes | ☐ No

If Yes, how often: _____ How long: _____

Type of Exercise? _____

7. Are you frequently sick or ill? ☐ Yes | ☐ No

If Yes, please explain: _____

8. Have you ever taken hormone or thyroid medications? ☐ Yes | ☐ No

If Yes, please explain: _____

9. Have you ever been under the care of a psychologist or psychiatrist?

If Yes, please explain: _____ ☐ Yes | ☐ No

10. Do you understand that medical and surgical treatments cannot promise or guarantee a good outcome?

◆ Yes ◆ No

11. Do you understand that all risks and complications cannot be prevented when a surgical procedure is performed?

◆ Yes ◆ No

◆ ***Women Only***:

Is there a history of breast cancer in your family? ◆ Yes ◆ No If yes, please specify _____

Do you have previous breast mass, suspicious biopsy, or cancer? ◆ Yes ◆ No

Are you currently or trying to get pregnant? ◆ Yes ◆ No

Do you have a history of gynecological problems? ◆ Yes ◆ No

◆ ***Men Only***:

Have you ever had prostate ◆ Yes ◆ No

If yes, please specify _____

Do you use sexual performance drugs such as Viagra, Levitra, ◆ Yes ◆No

Patient's signature_____ Date _____

Physician's signature_____ Date _____

Reviewed by_____ Date _____

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Notice of Privacy Practices (HIPAA)

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY

Law Requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. If there should be any future changes to this policy, an updated copy will be mailed to you.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information to our health care operations to support the business activities of our practice. We may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you.

NOTIFICATION: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information about you.

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Fax 714-839-8008

Email graphsurgery@gmail.com
Website www.tranplastic.com

ADDITIONAL USES AND DISCLOSURES

As required by law. We may use and disclose your health information when required to by federal, state, or local law.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Worker's Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. If you request copies, we may charge you for the costs of copying, mailing, or other supplies used in fulfilling your request.

2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions. You must request in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years. You are entitled to one list per year without charge. There is a charge for additional lists within the 12 month period.

3. Request that we place additional restrictions on our use or disclosure of your medical information. You may request we do not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

4. Request that we communicate with you about your medical information by different means or to different locations. You may request that we call you only at your work number, or by mail at a special address. Your request must be in writing.

5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

Complaints: If you believe we may have violated your privacy rights, you may file a complaint in writing within 180 days of the suspected violation. You may file this directly with the Privacy Officer c/o Tuan A. Tran, MD 10301 Bolsa Ave suite 101. Westminster CA 92683

Initial: _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this form, you acknowledge receipt of the **Notice of Privacy Practices** of **Tran Plastic Surgery**

Our **Notice of Privacy Practices** provides information about how we may use and disclose your protected health information.

Our **Notice of Privacy Practices** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Office at 714 839- 8000.

I have received the **Notice of Privacy Practices,** and I have reviewed it.

Please Print Name: _____
(patient/guardian/responsible party)

Signature:_____Date: _____

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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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Medical Records Release Form

(Print name and sign if we need to request records at any given time for any reason regarding your care.)

I,_____, provide my consent for the following medical records to be released
(print name)

to Dr. Tuan A. Tran's office. Please immediately fax these records to (714) 839-8008.

Patient DOB: _____

Patient Signature: _____

(Office use only)

Requesting:

- ☐ All medical records
- ☐ Radiology records (ex: reports/films/CD)
- ☐ Lab tests (ex: blood work/pathology)
- ☐ Hospital/Surgical records (ex: operative report)
- ☐ Clinical notes (ex: EKG, progress note, EMG report; Psychiatrist note)
- ☐ Clearance note (ex: Medical/ Cardiac Clearance; Psychiatrist clearance)
- ☐ Other: _____

Requested by:_____ Date: _____

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PHOTOGRAPHIC CONSENT AND RELEASE FORM
(REQUIRED)

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 medical records, authorization, and informing the medical profession about plastic surgery. 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: _____

MARKETING CONSENT AND RELEASE FORM

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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