Robert M. Wald, Jr., M.D., Inc.

Fellow of American College of Surgeons
Diplomate American Board of Plastic Surgery
Plastic, Reconstructive and Cosmetic Surgery

NOTICE OF PRIVACY PRACTICES WHO WILL FOLLOW THIS NOTICE

It is the policy of the medical practice that our employees and Business Associates comply with our Notice of Privacy Practices, which is consistent with HIPAA and California Law.

OUR PLEDGE REGARDING MEDICAL INFORMATION

- Ensure that medical information that identifies you is kept private;
- Provide you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW THIS MEDICAL PRACTICE MAY USE OR DISCLOSE HEALTH INFORMATION

We may use and/or disclose medical information...

- **Treatment:** ...to provide medical care and to our employees and others who we are involved in providing the care of our patients as needed.
- **Payment:** ...to obtain payment for the services we provide.
- **Health Care Operations:** ...to operate this medical practice.
- **Appointment Reminders:** ... to contact and remind our patients about appointments
- **Sign-in-Sheet:** ... about our patients by having them sign in when they arrive at our office. We may also call their name when we are ready to see them.
- **Notification and communication with family:** ...to notify or assist in notifying family members, personal representatives or other persons responsible for their care, or who is involved with the patient's care or helps pay for care. In the event of a disaster, we may disclose information to a relief organization. The patient has the right to agree or object to this disclosure. If the patient is unable to agree or object, our heal care professional will use their best judgment in communication with the patient's family or others.
- **Marketing:** ...when contacting our patients to give them information about products or services related to their treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may of interest to them. We may also encourage them to purchase a product or service we offer.. We will not otherwise use or disclose our patient's medical information for marketing purposes without their written authorization.
- **Required by Law:** ...when required to do so by federal, state, or local law, and for peer review.
- **Other uses of Medical Information:** ... as required by law to public health authorities, to health oversight agencies, a court or administrative order, or in response to a subpoena, to law enforcement, military or national security organizations, coroners, organ or tissue donation organizations, public safety and to comply with worker's compensation laws.

Except as described in our Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies individual patients without their written authorization. If a patient authorizes this medical practice to use or disclose health information for another purpose, the patient may revoke the authorization in writing at any time.

OUR PATIENTS' HEALTH INFORMATION RIGHTS

Our patients have the right to...

- **Right to Request Special Privacy Protection**:... request restrictions on certain uses and disclosures of their medical information, by written request. We reserve the right to accept or reject these requests, and will notify each patient of our decision.
- **Right to Request Confidential Communications:**...request that they receive their health information in a specific way or at a specific location. We will comply with all reasonable requests submitted in writing which specify how or where they wish to receive these communications.
- **Right to Inspect and Copy:**... inspect and copy their health information, with limited exceptions. To access, a written request detailing the information they want and whether they want to inspect it or get a copy of it. We will respond to every written request within the time required by California and Federal Law. We will charge a reasonable fee, as allowed by California and Federal Law. We may deny request under limited circumstances.
- **Right to Amend or Supplement:**...make request in writing , and include the reasons they believe the information is inaccurate or incomplete, if they feel that medical information we have about them is incorrect or incomplete. Our office will retain the amended information. We are not required to change health information, and if we refuse, we will provide them with information about this medical practice's denial and how they can disagree with denial.
- **Right to an Accounting of Disclosure:**...a paper copy of this Notice of Privacy Practices, upon request.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with our office, ATTN: Management, or with the Secretary of the Department of Health and Human Services. All complaints must be submitted. YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

Patient's Legal Signature	Patient's Name (Print)	Date
Parent or Guardian Legal Signature	Parent or Guardian legal Name (Print)	Date
Office Staff Signature		Date

100 E. Valencia Mesa Drive, Suite 300, Fullerton, CA 92835
(714) 738-4282 • (714) 738-1862 fax

SOCIAL HISTORY & HABITS

SEX: _____ HEIGHT: _____ WEIGHT: _____

MARITAL STATUS: MARRIED☐ SINGLE☐ DIVORCED☐ WIDOW(ER)☐

SMOKE: Y☐ N☐ AMOUNT PER DAY: _____

COFFEE/TEA/COLA: Y☐ N☐ AMOUNT PER DAY: _____

ALCOHOL: Y☐ N☐ AMOUNT PER DAY: _____

EXERCISE: Y☐ N☐ HOW OFTEN: _____

PRIMARY CARE PHYSICIAN: _____ DATE LAST SEEN: _____

PRESCRIPTION MEDICATIONS: □ Yes □ No If yes, please list below

_____

VITAMINS/HERBS/OTHER NON PRESCRIPTION MEDICATION: □ Yes □ No If yes, please fill out Medication Reconciliation List _____

_____

Regular Aspirin/NSAID use: Y☐ N☐ Dosage & Frequency: _____

Cortisone Injection in past year: Y☐ N☐ Dosage & Frequency: _____

Accutane Past 6 months: Y☐ N☐ Dosage & Frequency: _____

ALLERGIES: NONE☐ DRUG☐ LATEX☐ TAPE☐ please list allergy and reaction: _____

_____

_____

PERSONAL, CURRENT, & PAST HISTORY

Abnormal Bleeding: Y☐ N☐ Acid Reflex: Y☐ N☐ Anemia: Y☐ N☐ Asthma: Y☐ N☐

Cancer: Y☐ N☐ Diabetes: Y☐ N☐ Fainting: Y☐ N☐ Heart Disease: Y☐ N☐

Thyroid: Y☐ N☐ Hepatitis: Y☐ N☐ Hypertension: Y☐ N☐ Kidney Disease: Y☐ N☐

Nausea/Vomiting: Y☐ N☐ Sleep Apnea: Y☐ N☐ Snoring: Y☐ N☐ Urinating Probs: Y☐ N☐

Other Serious Illness: Y☐ N☐ **Please describe yes answers**: _____

_____

Psychological Disorder: Y☐ N☐ Describe: _____ Doctor name/#: _____

Weight change is the past 12 months: Y☐ N☐ Explain: _____

Have you ever received a blood transfusion? Y☐ N☐ When/explain: _____

Have you ever been tested for HIV? Y☐ N☐ What year? _____ Results: positive☐ negative☐

LIST PREVIOUS SURGERIES, PROCEDURES & YEARS: mark box for no previous surgery☐

_____

_____

Local Anesthesia: Y☐ N☐ **General Anesthesia:** Y☐ N☐ **Spinal/Epidural:** Y☐ N☐

Explain if you or any family member has had any complications from anesthesia: _____

_____

CONTACT LENSES: Y☐ N☐ EYE GLASSES: Y☐ N☐ HEARING AID: Y☐ N☐ DENTURES: Y☐ N☐

FAMILY HISTORY

Have any blood relatives ever have the following problems?

Abnormal Bleeding: Y☐ N☐ Anesthesia Problems: Y☐ N☐ Cancer: Y☐ N☐

Coronary Surgery: Y☐ N☐ Diabetes: Y☐ N☐ Heart Disease: Y☐ N☐

Kidney Disease: Y☐ N☐ Tuberculosis: Y☐ N☐ Hypertension: Y☐ N☐

Other: Y☐ N☐ **Please describe yes answers**: _____

_____

WOMEN ONLY

Number of pregnancies: _____ Number of children: _____ Breast feed: Y☐ N☐

Last menstrual period: _____ Normal menstrual period: Y☐ N☐ If No explain: _____

Hysterectomy: Y☐ N☐ Tubal ligation: Y☐ N☐ Bra Size: _____

PATIENT'S NAME (PRINT): _____ DATE: _____

the Aesthetic INSTITUTE

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PHOTO CONSENT

1. **Cosmetic surgery photos are taken before and after surgery for the patient's file only and patient's personal review. (Photos kept in patients file)**

2. **Insurance companies may require photos for medical review and pre-authorization or surgery. (Photos kept in patients file)**

PHOTO AUTHORIZATIONS

(Before and After Results)

YES NO

____ ____ Photograph Book Authorization
Robert M. Wald, Jr.,MD Photograph Books- Books are not removed from the premises and are used for consultation purposes only. (To help patients, like yourself, review before and after results.)

YES NO

____ ____ Photograph Website Authorization
Robert M. Wald, Jr., MD Website- www.drrobertwald.com
(To help patients, like yourself, review before and after results)

I understand that I will not be entitled to monetary payment.

Patient's Legal Signature:_____ Date:_____
Please Print Name:_____

Parent or Guardian (only if applicable) Signature:_____Date:_____
Please Print Name:_____

Office Signature:_____Date:_____

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ROBERT M. WALD JR., M.D. 100 EAST VALENCIA MESA DR., SUITE 300 FULLERTON, CA 92835' (714) 738-4282

PATIENT INFORMATION - ***PLEASE PRINT & USE BLACK INK TO COMPLETE THIS FORM***

LEGAL NAME _____ MI____ SS#_____ DOB_____AGE_____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ HOME PHONE (_____)_____ CELL PHONE (_____)_____

PATIENT'S E-MAIL ADDRESS_____

EMPLOYER _____TITLE/POSITION_____

ADDRESS _____CITY_____

STATE _____ ZIP _____ WORK PHONE (_____)_____ EXT. _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

(CIRCLE ONE) SPOUSE/PARENT/GUARDIAN/OTHER INFORMATION

NAME _____ MI ___SS#_____AGE_____

ADDRESS _____CITY_____

STATE _____ ZIP _____ HOME PHONE (_____)_____CELL PHONE (_____)_____

EMPLOYER _____ TITLE/POSITION _____

ADDRESS _____CITY_____

STATE _____ ZIP _____ WORK PHONE (_____)_____ EXT. _____

(PLEASE FILL IN COMPLETELY) INSURANCE INFORMATION

PRIMARY INSURANCE _____ HMO/IPA _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE _____

ID/CERTIFICATE # _____GROUP/CONTRACT # _____

SUBSCRIBER'S NAME _____ DATE OF BIRTH _____

I AUTHORIZE PAYMENT OF BENEFITS TO THE MEDICAL PROVIDER OR SUPPLIER FOR SERVICES RENDERED TO ME AND IF NOT COVERED BY THE HEALTH CARRIER I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR THE FEES FOR THE SERVICES RENDERED TO ME.

SECONDARY INSURANCE _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE _____

ID/CERTIFICATE # _____GROUP/CONTRACT # _____

SUBSCRIBER'S NAME _____ DATE OF BIRTH _____

IF IT BECOMES NECESSARY TO CONTACT YOU BY PHONE, DO WE HAVE YOUR PERMISSION TO LEAVE MESSAGES REGARDING LAB RESULTS AND/OR APPOINTMENTS ON ANSWERING DEVICE OR WITH ANOTHER PERSON WHO ANSWERS THE PHONE? ____YES ____ NO

WHERE DO YOU PREFER TO RECEIVE CALLS (1ST/2ND/3RD CHOICE) ? CELL _____ HOME _____ WORK _____

NAME OF EMERGENCY CONTACT (RELATIONSHIP/NOT LIVING WITH YOU) _____ PHONE _____

REFERRED BY (CIRCLE ONE) : SPOUSE/RELATIVE/FRIEND/GUARDIAN/WEBSITE/PHONEBOOK/PATIENT/DOCTOR/OTHER _____

LEGAL SIGNATURE: _____DATE: _____

PATIENT REPRESENTATIVE'S SIGNATURE _____DATE: _____