ALLURE
aesthetic&plastic
surgery

Percy H Lo, M.D

WELCOME TO OUR OFFICE

Please fill out this form as completely as possible so that we will get to know you and be of greater assistance.

PATIENT INFORMATION

Demographics

Last Name: _____ First Name: _____Age: _____

Date of Birth: _____ Social Security: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____

Employer Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse Name: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referred By: _____ Primary Care Physician: _____

Insurance Information

Primary Insurance Company: _____

Secondary Insurance Company: _____

Pharmacy Information

☐ **CVS** ☐ **Publix** ☐ **Target** ☐ **Sam's Club** ☐ **Walgreens** ☐ **Sweet Bay** ☐ **Wal-Mart**

☐ **Other** _____

Pharmacy Phone: _____ Address: _____

I, _____ am ultimately responsible for full payment for my treatment and care. My insurance policy is a contract between Allure Aesthetic & Plastic Surgery and my insurance. Allure Aesthetic & Plastic Surgery will file my claim, however, I am required to provide most correct and updated information about my insurance, and will responsible for any charges incurred if information provided is not correct or updates. **Patients are responsible for the payment of all co-pays, coinsurance, deductibles and other procedure and treatments and exclamations of any serviced not covered. Payment is due at the time of services rendered.** For your convenience we except cash, check, and most major credit cards.

X _____ Date: _____

Patient Signature

PATIENT CASE HISTORY

Patient Name: _____ **Date:** _____

Height: _____ **Weight:** _____

Chief complaint/Reason for visit: _____

Duration of Present Condition: _____

Medications (Including Vitamins and Herbals Supplements)

	Medication Name	Dosage	Frequency	Reason for Taking	Prescribed By
1.					
2.					
3.					
4.					
5.					
6.					

Do you take any blood thinners? ☐ **Yes** ☐ **No**

If yes, please list: _____

Medication Allergies

Are you allergic to any medications? ☐ **Yes** ☐ **No**

If yes, what medication(s) _____

What is your reaction to this medication? _____

Past Medical History

☐ High Blood Pressure ☐ Diabetes Mellitus ☐ Bleeding Problems ☐ Hepatitis ☐ Skin Cancer

Previous Surgery

Type	Date

Social History

Do you smoke? ☐ **Yes** ☐ **No** **If so how many pack per day?** _____

Have you ever smoked ☐ **Yes** ☐ **No**

Family History (Please list)

_____

_____

REVIEW OF SYSTEMS

*Please check off all that apply or select **NONE** if none apply*

Patient Name: _____ **Date:** _____

Eyes
- ☐ Visual Problems
- ☐ Blurry Visions
- ☐ Red Eyes
- ☐ **NONE**
- ☐ Other _____

Ears
- ☐ Hearing Problems
- ☐ Ringing In Ears
- ☐ Discharge
- ☐ **NONE**
- ☐ Other _____

Throat
- ☐ Swallowing Difficulty
- ☐ Frequent Sore Throats
- ☐ Speech Problems
- ☐ **NONE**
- ☐ Other _____

Oral
- ☐ Dental Problems
- ☐ Tongue Problems
- ☐ Canker Sores
- ☐ **NONE**
- ☐ Other _____

Neck
- ☐ Swollen Glands
- ☐ Thyroid Problems
- ☐ **NONE**
- ☐ Other _____

Chest
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ **NONE**
- ☐ Other _____

Heart
- ☐ Murmurs
- ☐ Pace Maker
- ☐ Palpitations
- ☐ Valve Problems
- ☐ Heart Failure
- ☐ Heart Attack
- ☐ Angina
- ☐ **NONE**
- ☐ Other _____

Intestinal
- ☐ Colitis
- ☐ Ulcer Gastritis
- ☐ Barrett's Esophagus
- ☐ Polyps
- ☐ Constipation
- ☐ **NONE**
- ☐ Other _____

Urinary
- ☐ Urinary Problems
- ☐ Frequency
- ☐ Burning
- ☐ Kidney Stones
- ☐ **NONE**
- ☐ Other _____

GYN
- ☐ Pregnant
- ☐ Breast Feeding
- ☐ Last Menstrual Period _____
- ☐ **NONE**
- ☐ Other _____

Spine
- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Scoliosis
- ☐ Herniated Disc
- ☐ Sciatica
- ☐ **NONE**
- ☐ Other _____

Upper Extremity
- ☐ Pain In Arm
- ☐ Carpal Tunnel
- ☐ Shoulder Pain
- ☐ Elbow Pain
- ☐ Wrist Pain
- ☐ **NONE**
- ☐ Other _____

Lower Extremity
- ☐ Pain In Legs
- ☐ Pain In Knee
- ☐ Pain In Hips
- ☐ Ankle Pain
- ☐ Tingling
- ☐ **NONE**
- ☐ Other _____

Systemic
- ☐ Weight Loss
- ☐ Fever
- ☐ Night Sweats
- ☐ Trouble Sleeping
- ☐ Loss of Energy
- ☐ Arthritis
- ☐ **NONE**
- ☐ Other _____

Neurological
- ☐ Headache
- ☐ Convulsions / Seizures
- ☐ Fainting
- ☐ ADD
- ☐ Stroke
- ☐ **NONE**
- ☐ Other _____

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Stress/Excess Worry
- ☐ Drug / Alcohol Issues
- ☐ **NONE**
- ☐ Other _____

ALLURE AESTHETIC & PLASTIC SURGERY, PERCY H LO, MD
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, and treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other healthcare professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.

To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, mobile voice mail, email or with a household family member.

[ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.

[ ] Please check here if you do not want us to leave a message on your mobile voice mail.

[ ] Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.

To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information_____

_____

You may request a copy of and you have the right to read our "*Notice of Patient Privacy Practices"* prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.
Patient Name (please print):_____

_____ _____ _____
Signature Printed Name of Guardian or Representative Date

*If other than patient is signing, are you the parent, legal guardian, or legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ] RELATIONSHIP_____

FOR OFFICE USE ONLY
Patient refused to sign the form. Reason: _____