Photo Id# _____
For Insurance Patients

Lake Oswego Plastic Surgery
PATIENT INFORMATION

Patient Chart _____

PATIENT INFORMATION

Name: _____
First Middle Initial Last Name

Address: _____

City, State, Zip _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

WHAT IS THE REASON FOR YOUR VISIT TODAY?:

Date of Birth: _____ Sex: _____

Social Securty: _____

Marital Status S M W D Other

Spouse/Partner _____

Spouse/Partner Social Securtiy: _____

Spouse /Partner/Employer: _____

Emergency Contact: Phone Relationship

PATIENT'S EMPLOYMENT INFORMATION

{ } Employed { } Retired { } Other

Address: _____

Employer: _____

City, State, Zip _____

GUARANTOR INFORMATION { } Same as Patient

Name: _____

Social Sec. # _____

Address: _____

City, State, & Zip: _____

Employer: _____

Home Phone: _____

Work Phone: _____

Date of Birth: _____

PRIMARY INSURANCE INFORMATION

{ } Patient { } Same as Guarantor { } Other

Insured Party Name: _____

Insured Employer: _____

Insurance Company: _____

Insured ID: _____

Social Security #: _____

Insured's Date of Birth:

SECONDARY INSURANCE INFORMATION

{ } Patient { } Same as Guarantor { } Other

Insured Party Name: _____

Insured Employment: _____

Insurance Company: _____

Insured ID: _____

Social Security #: _____

Insured's Date of Birth:

ACCIDENT RELATED INJURY: Work, Auto, Other . Circle One. Must be completed if injury is related to Work or Auto

Insurance Company Name: _____

Address: _____

City, State, Zip: _____

Date of Injury: _____

Claim Number: _____

Phone: _____

Attorney Name if _____

All professional services are charged to the patient. If there is insurance involvement, we will bill the insurance. However, the patient is responsible for all fees, regardless of insurance coverage. If you are a a cosmetic patient, consult fee is due day of consult. Surgical fees are due two weeks before surgery, unless prior arrangements has been made. I understand my signature requests that payment be made, and authorizes release of medical information necessary to pay the claim. The patient is responsible for any and all appropriate referrals. The patient is responsible for only the deductible, coinsurance and non-covered services.

_____ Date: _____

Signature of Patient, Guarantor or Parent if patient is under 18

Lake Oswego Plastic Surgery
MEDICAL HISTORY

PATIENTS NAME: _____ *Primary Care Physician:* _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

ALLERGIES: _____ MEDICATIONS: _____

_____ _____

_____ _____

_____ _____

_____ _____

PERSONAL HISTORY:

Do you currently have or have you ever had problems:

	Yes	NO		Yes	NO
Asthma	☐	☐	Mobility	☐	☐
Shortness of Breath	☐	☐	Arthritis	☐	☐
Chest Pains/ Angina	☐	☐	High Blood Pressure	☐	☐
Cancer	☐	☐	Stroke	☐	☐
Depression	☐	☐	Liver Dysfunction	☐	☐
Spastic Colon	☐	☐	Abdominal Pain	☐	☐
Pregnancy	☐	☐	Breast Mass / Pain	☐	☐
Gall Bladder Attacks	☐	☐	Kidney/ Bladder	☐	☐
Vision-Contacts/Glasses	☐	☐	Hearing	☐	☐
Speech Problems	☐	☐	Diabetes	☐	☐
Prostate	☐	☐	Frequent Urination	☐	☐
Hepatitis	☐	☐	TB/ Tuberculosis	☐	☐
Bleeding Excessively	☐	☐	Dizziness / Fainting	☐	☐
Swelling of the Extremities	☐	☐	Bruise Easily	☐	☐
Back or Neck Pain	☐	☐	Headaches	☐	☐
Do You Drink?	☐	☐	Do You Smoke?	☐	☐

If Yes, How much_____ If Yes, How much_____

If you answer YES to any of the questions. Please give a brief explanation: _____

_____

_____

Previous Surgeries:

Operations: Surgeon/Facility: Year:

_____

_____

_____

Post Surgery Problems: *Please Circle* NAUSEA? VOMITING? CONSTIPATION? DIFFICULT BREATHING? HEADACHES? BLEEDING? WAKING UP?

Miscellaneous Medical Problems not listed: _____

_____

PATIENT SIGNATURE: _____ DATE:_____

TUAN A. NGUYEN, M.D., D.D.S.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, *(Please print your Name)*_____,
have been presented with a copy of this office's Notice of Privacy Practices to read. I may have a copy of the Privacy Practices Notice if I request it.

Signature:_____

Date:_____

The following is for office use only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__Individual refused to sign

__Communication barriers prohibited obtaining the acknowledgement

__An emergency situation prevented us from obtaining acknowledgement

__Other (please specify)

_____

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer".

Tuan A. Nguyen, M.D., P.C.
15820 Quarry Rd.
Lake Oswego, OR 97035

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775