Norman Leaf MD FACS

PLASTIC & RECONSTRUCTIVE SURGERY

NEW PATIENT INFORMATION

NORMAN LEAF, M.D. F.A.C.S.
436 North Bedford Drive
Suite 104, Beverly Hills, CA 90210

Tel · (310) 274.8001 **Fax** · (310) 421.1436
Email: caroline@leafmd.com

Thank you for scheduling a consultation. We look forward to meeting you and discussing your desires regarding plastic surgery. Enclosed are patient information forms, please review the information prior to your consultation.

In order to minimize your wait time, **please complete the enclosed new patient forms prior to your visit**, you may email, mail, fax or bring the completed forms with you. In the meantime, if you have any questions at all, please feel free to contact me. I look forward to meeting you.

Sincerely,

Caroline Alexander
Patient Coordinator

Enclosures

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(Please Print Legibly)

Patient Information as of ___________________ (enter today's date)

Patient's Name ____
First Middle Last

Address ____
Street & Apt # City State Zip

Home Phone______________________Cell Phone___________________e-mail_______________________________

Date of Birth______________________________Age________Social Security #_______________________________

Gender: Female_______Male________ Marital Status: Single___ Married___ Domestic Partner___Other_____

Emergency Contact Name____**Relationship**_____________________

Home Phone____________________________Cell Phone______________________Work Phone_______________

How did you hear about Dr. Leaf?

What are your major concerns?

What would you consider are your secondary concerns?

I understand that office visit charges are payable on the day service is rendered. I understand that the consultation fee is for Dr. Leaf's time and professional opinion regarding procedures I am interested in. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr.Leaf and myself.

Signature ____**Date** ______________________

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Health Information as of________________(enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name:___________________________________Reason for Visit: ____

Age:__________________Height: _______Feet _______Inches Weight: ____________Lbs.

Current Physician(s): ____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Problems / Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetics	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes			
Ear Infection	No	Yes	High Blood Pressure	No	Yes			

Do you smoke? No Yes If yes, how much?__________Pack(s)/day How long?__________Years

Do you drink alcohol? No Yes If yes, how much?____________________How often?

Do you use recreational drugs? No Yes If yes, describe:

Do you have bleeding or bruising problems? No Yes If yes, describe:

Do you have problems with scarring? No Yes If yes, describe:

Do you have any history of problems with anesthesia? No Yes If yes, describe:

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies.

The above information is accurate and complete to the best of my knowledge.

Signature ____Date __________________________

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Notice of Privacy Practices - Patient Acknowledgement Form

This is a general summary notice of our privacy practices and briefly 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 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.

Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Provide or post a copy of the full 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. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Your Individual Rights

1. Look or get copies of certain parts of your medical information. You must make your request in writing (There may be a service charge for copies of medical records, and allow at least 5-7 business days for copies to be prepared.)
2. Receive a list of all times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement.
4. 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. If we accept your request to change the information, we will make reasonable efforts to tell others of the changes made. Include the changes in any future sharing of that information.
5. If you have received this notice electronically, and you wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to us.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

Date: ________________________________ Full Name: __________________________________

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