P: 813-579-3369 & F: 866-202-3227
www.wayneleemd.com

Brandon Office
1020 E. Brandon Blvd, Suite 101
Brandon, FL 33511

Tampa Office
3000 Medical Park Dr. Ste 140
Tampa, FL 33613

Patient History

Date:____________________________

Patient Name: ____ MI: ______

Address: ____ City: __________ State: ______ Zip:

Phones: (Home): ______________________________ (Cell): ______________________________

Email: ____ (If you would prefer not to receive email communication from WLMD & Real Self, please leave the email line blank.)

Social Security #: __________-_________-______________

Driver's License #: _______________________ State: _____Exp: _____

Age: _______ Birthdate: (mm/dd/yy): _____ /_____ /_____ Gender: M / F Ethnicity: __________________(opt)

Height: ______ ft _______ in. Weight: ___________ lbs

Occupation: ____ Employer: ____

Marital Status (please circle one): Single – Married – Widowed – Divorced – Separated

Spouse's Name: ______________________________________

Family Physician:______________________________________

Other Physician: ______________________________________

Emergency Contact, Name: __________________________________ Relation: ____________________ Ph: ___________________

Nearest relative not living with you: ______________________________ Relation: ___________________________________

Phone: ____

Address: ____ City: _____________________ State: ______ Zip: ____________

Reason for today's Visit:____

____

Confidential Health Information Release

Name (Print): _____________________________________ MI: ______

I authorize this medial office or its affiliates to leave confidential health information voicemail at the following phone number if I'm not available: _______________________________________Type of Ph: H / W/ Cell

I authorize this medical office or its affiliates to send confidential health information to the following address:

____City: _________________________ State: _______ Zip: _________________

Signature: ___________________________ Date:_________________

Patient Name:_____________________

Insurance Information

Primary Policy Holder (Name): ____

Relation to patient: ____

Subscriber Birthdate: ______ / ______ / ______ Subscriber Social Security #: ________ - _____ - _____________

Primary Insurance Co: ____ Phone: _______________________

Policy #: ____ Acct #: ___________________ Group #: _______________

Secondary Insurance Co: ____ Phone: ____________________________

Subscriber Name: _______________________________________ Relation to patient: _____________________________

Policy #: ____ Acct #: ___________________ Group #: _______________

Person Responsible for bill: _____________________________________ Phone: _______________________

Check below all illnesses that you have/had:

____ Allergies ____ Asthma ____ Bleeding Tendencies ____ Diabetes ____ Epilepsy
____ Diverticulosis ____ Eczema ____ Depression/Anxiety ____ Emphysema ____ Glaucoma
____ Eye Disease ____ Reflux ____ Gastroesophageal ____ Glaucoma ____ Hernia

____ Heart Disease ____Gout ____ Heart Disease ____ Hemorrhoids ____ Thyroid
____ Kidney Disease ____ Neuritis ____ Liver Disease ____ Tuberculosis ____ Pancreatitis
____ Osteoarthritis ____ Stroke ____ Ulcers (Duodenal) ____ Irritable Bowel Syndrome
____ Ulcers (leg) ____ Rheumatic Fever ____ Hepatitis, Type:___________________
____ Obstructive Sleep Apnea ____ High Blood Pressure ____ Cancer/Tumors. Type: ___________________

Sexually Transmitted Disease, Type: ___________________________________

Do you have a pacemaker? ____ Yes, ____ No Are you HIV positive? ____ Yes, ____ No

List all other illnesses you've had: ____

____

____

Operations

Type Month/Year Surgeon/Hospital

____

____

____

____

____

Pregnancies

Number of Pregnancies:_______________

Number of Children:

Males _______________ Ages: _______________ Females _______________ Ages: _______________

Patient Name: ___________________

Medications

Are you currently taking any medications: Yes ____ No ____ Please list all medications:

Are you currently taking any of the following blood thinners? Please circle.

Aspirin	Plavix	Warfarin (Coumadin)	Fish Oil	Fragmin
Coumadin	Dicumarol	Miradon	Clexane	Arixta
Orgaran	Innohep	Argatroban	Reludan	Angiomax
Pradax	Plavix	Persantine Aggrenox		

Allergies

Pencilin (reaction):	Cephalosporin(e.g. Keflex)(reaction):
Sulfa (reaction):	Aspirin (reaction):
Codeine (reaction):	Morphine (reaction):
Latex (reaction):	Other (reaction):

Social History

Smoking: (circle) YES, NO, QUIT: _____ Types: _____Cigarettes, ____ Cigars, _____ Chewing Tobacco
Packs per Day: ____________ Years Smoked: ___________
Alcohol: (circle) YES, NO, QUIT # of Drinks per Week: ______________
Illegal Drugs: (circle) YES, NO, QUIT Type: ________________ Frequency: ___________ IV Drugs? Y/N
Exercise: (circle) YES, NO, QUIT Activity: __________________________ Frequency:

Family Medical History

Have you or anyone in your family had problems with anesthesia? _____ Yes, _____ No
Check below if any of the following conditions have occurred on either side of the patient's family:

____ Allergies	____ Bone Disease	____ Diabetes
____ Breast Cancer	____ Kidney Disease	____ Tuberculosis
____ Melanoma Skin Cancer	____Thyroid Disease	____ Pulmonary Disease
____ Other Cancer	____ Congenital Deformities	____ Bleeding Tendencies
____ Gastrointestinal Disease	____ Heart Disease/Cardiovascular	____ Keloid Scars

Other (please list all):

Patient Name: ____________________

Review of Symptoms

Constitutional:	____ Weight Loss	____ Fatigue	____ Fever
Cardiovascular:	____ Chest Pain	____ Cyanosis	____ Shortness of Breath
	____ Ankle Edema	____ Frequent Urination at Night	
Respiratory:	____ Cough	____ Coughing Blood	____ Wheezing
	____Use of Oxygen	____ Shortness of Breath	
Musculoskeletal:	____ Pain	____ Tenderness	____Muscle Weakness
	____ Joint Swelling		
Endocrine:			
	____High Blood Sugar	____ Excessive Thirst	____ Intolerance of Heat or Cold
Hematology/Lymphatic:			
	____ Anemia	____ Bruise Easily	____ Enlarged Lymph Node
Allergy/Immunologic:	____ Itchy	____ Frequent Infection	____ Inhalant or Food Allergy
GU:	____ Burning	____ Urinary Infections	____ Urine in Blood
Eyes:	____ Blindness	____ Red Eyes	____ Double or Blurry Vision
Skin:	____ Rash	____ Lumps	____ Sores
	____ Loss of Hair		
Psych:	____ Anxiety	____ Sleep Disturbances	____ Nervousness
	____ Memory Loss		
GI:	____ Nausea	____ Vomiting	____ Diarrhea
	____ Vomiting Blood	____ Indigestion	____ Difficulty Swallowing
Neuro:	____ Paralysis	____ Head Injury	____ Head Aches
	____ Numbness	____ Blackouts	

How were you referred to our office? Please check all that apply.

____ Physician Referral & Physician Name:____________________

____ Hospital Affiliation & Name:____________________

____ Patient Referral & Name:____________________

____ Word Of Mouth	____ Driving By	____ E-Mail	
____Website	____ Facebook	____ Tampa Bay Surgical Arts	
____ Bella Medspa	____ RealSelf	____ Yelp	
____ Citysearch	____Vitals	____ Healthgrades	
____ Merchant Circle	____ Insider Pages	____ Thumbtact	____ Return 2 Fitness

Patient Name: ______________________

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ____, understand that as part of my healthcare, Wayne Lee MD Plastic Surgery, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plan for future plan for treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided a Notice of Privacy Practices that provides more completed description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Wayne Lee MD Plastic Surgery PLLC is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance there on. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse treatment as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Wayne Lee MD Plastic Surgery PLLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Wayne Lee MD Plastic Surgery PLLC change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to use or disclosure of my health information:

____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

Patient Signature: Date:
____

Patient Name: ________________

Lifetime Authorization Insurance Assignments & Authorization to Release Information

Release of Information
I, the below named patient, do herby authorize any physician examining and/or treating me to release to any third party (such as an insurance company or government agency, example: Medicare) any medical condition, psychiatric condition, alcohol, or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for such treatment and/or diagnosis.

Physician Insurance Assignment
I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services.

Medicare/Medicaid
Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or any other information about me to release to Administration/Division of Family Services or its intermediaries/carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician/group treating me.

Guarantee of Payment
I, the below named patient/guarantor, does hereby guarantee payment of all charges incurred for the account of the patient named below. I further agree to waive demand and notice of non-payment in protest: and in case suit shall be brought for the collection hereof, of the same is collected upon demand of any attorney. I agree to pay all cost of collection, including reasonable attorney fees.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand that it is my responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 60 days.

Patient Signature: Date:

____

Subscriber (If Different From Patient): Witness:

____

Patient Name: ____________________

Member Authorization Form for Designated Representative to Appeal a Determination

Member Name: ____ Date:_____________________

Member #: ____

I hereby authorize Wayne Lee MD Plastic Surgery or any representative thereof as my Designated Representative, to appeal any of my insurance company's determination on my behalf.

I hereby authorize my insurance company ____________________________________ in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that tested to treatment but no lie communications may contain the following:

> All medical and financial information contained in my insurance file, including but no , limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment, and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization is valid for a period of two years.

Signature of Member or Legal Guardian/Representative:

____

Signature of Witness:

____

Name of Witness/Designated Representative:

____

Patient Name:______________________

Authorization For & Release of Medical Photographs, Slides, and/or Videotapes

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

Medical photographs, slides, and videotapes may be taken before, during, or after surgical procedure of treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs, slides, and videotapes for a stated purpose.

Consent to Take Photographs, Slides, and/or Videotapes

I hereby authorize Wayne Lee MD Plastic Surgery and/or his associated or licensees to take pre-operative, intra-operative, or post-operative photographs, slides, and/or videotapes.

Consent for Release of Photographs, Slides, and/or Videotapes

I hereby authorize Wayne Lee MD Plastic Surgery and/or his associate or licenses to use pre-operative, intra-operative, or post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to show these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, advertising purposes, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment of any other consideration as a result of any use of the images.

Patient Signature: Date: