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

New Patient Form

Date:____________________

Patient Name:____ MI: _______

Address:____City:____________State:______Zip: ______________

Cell phone #:____Home phone #: _______________________________

Email:____

(If you would prefer not to receive email communication and promotion from WLMD 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 (circle): Single, Married, Widowed, Divorced, Separated Spouse's Name: ______________________________

Emergency Contact:

Name:____Relationship:_____________Phone #:_________________________

Nearest relative not living with you:______________________________Relationship:_________________________________

Phone #:____Address:____

City:______________________ State:_________Zip: _______________

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 Phone: Home / Work / Cell

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

Address:_____________________________________City:_________________________State:________Zip: __________

Signature:___________________________________Date: _________________________

Reason for today's visit: ____

Referring Physician:_: _____________________________________

Family Physician: ____

Other Physician:____

Patient Name: ___________________________

Pharmacy Information

Pharmacy name: ______________________________

Phone number: _______________________________

Address: _____________________________________

Fax number: _________________________________

Social History

SMOKING: (circle) YES NO QUIT: __________ Type: Cigarettes______Cigars______Chewing Tobacco ______

ALCOHOL: (circle) YES NO QUIT: __________ # of drinks per week: ____________

ILLEGAL DRUGS: (circle) YES NO QUIT: ________ Type: _______________Frequency: _______IV Drugs? Y/N

Surgeries

Type	Month/Year	Surgeon/Hospital

Pregnancies

Number of Pregnancies: ___________Number of Children: _______________

Males___________________ Ages: ___________________ Females___________________ Ages: ___

Medications

Are you currently taking any medications: Yes_____No______

Please list all medications: ____

____

Are you currently taking any of the following *blood thinners*? (circle)

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

Allergies

Penicillin (reaction):	Cephalosporin(e.g. Keflex)(reaction):
Sulfa (reaction):	Aspirin (reaction):
Codeine (reaction):	Morphine (reaction):
Latex (reaction):	☐ No Known Drug Allergies

Please list all allergies/reaction: ____

Patient Name: ___________________________

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): ___________________________________

Personal Medical History

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: ____

Are you HIV positive? Yes_____NO_____

Do you have a pacemaker? YES_____NO______

List all other illnesses you've had: ____

____

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 FoodAllergy

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 _____Email
_____Website _____Facebook _____Tampa Bay Surgical Arts
_____Bella Medspa _____RealSelf _____Yelp
_____Citysearch _____Vitals _____Healthgrades _____Google
_____Merchant Circle _____Insider Pages _____Return 2 Fitness

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 Name (Please Print):

____

Patient Signature: Date

____

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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 Name (print): ______________________________

Patient Signature: ______________________________

Date: ______________

I agree for my images to be shown for teaching purposes AND for my medical record but **NOT for social media:**

Patient Signature: Date:

____

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Medical Records Request/Release Form

Patient Name: ____

Patient DOB:____________________SSN:_________________________

I hereby authorize Wayne Lee MD Plastic Surgery, PLLC *to Release/Request* my medical Records *to/from*:

Name:____

Location
Address:____

____

Phone:______________________________Fax:__________________________

Email: ____

Reason for Request: ____

Date needed: ______________________

Records Needed: (Please specify which medical records are needed for the above patient. For instance, Doctor's office visit notes, operative reports, prescriptions, lab work, diagnostic test results, x-rays, MRI Results, etc. Doing so will help with efficiency in processing the request. Thank you for your cooperation.)

____

____

____

Patient's Signature____________________________________Date:________________

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I would like to know more about the following…

Surgical Procedures:

- ☐ Breast Augmentation
- ☐ Revision Augmentation
- ☐ Mastopexy (Breast Lift)
- ☐ Breast Reduction
- ☐ Gynecomastia
- ☐ Abdominoplasty
- ☐ BBL (Brazilian Butt Lift)
- ☐ Liposuction
- ☐ Eyelid/Brow lift
- ☐ Facelift
- ☐ Necklift
- ☐ Arm lift
- ☐ Thigh lift
- ☐ Cellulaze for Cellulite
- ☐ Smartlipo
- ☐ Other: ______________________________

Non Surgical Procedures:

☐ **BOTOX**

☐ **Dermal Fillers**

☐ JUVÉDERM® ULTRA ☐ JUVÉDERM® ULTRA PLUS ☐ JUVÉDERM® VOLUMA™ XC
☐ JUVÉDERM® VOLLURE™ XC

☐ **Coolsculpting** is a FDA-cleared to eliminate stubborn fat in 9 different areas of the body including under the chin and jawline areas, thighs, abdomen and flanks, along with bra fat, back fat, underneath the buttocks, and upper arms.

☐ **TempSure** is a non-invasive laser treatment that uses Radio Frequency energy to tighten loose skin on the Face and Body.

☐ TempSure Envi ☐ TempSure Firm ☐ TempSure Vitalia ______________________________

☐ **Facials**

☐ **ZO Skin Health Skincare**

☐ **Latisse** is an FDA-approved treatment to grow eyelashes for people with inadequate or not enough lashes.

☐ **Other:**