SURGICAL ARTISTRY
PATIENT HEALTH HISTORY
Dr. Tammy Wu, Board Certified Plastic Surgeon
Dr. Calvin Lee, Board Certified General Surgeon

Veins • Acupuncture • Plastic Surgery
Surgical Artistry

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (Circle One)
					Single / Mar / Div / Sep / Wid

Patient Birth Date:	Patient Age:	Children:	Patient Gender:		E-Mail Address:
/ /			❑Female	❑ Male	

Other Friends and Family Members Seen Here:	Home Phone No.:	Is it Okay To Leave A Message?	Cell Phone No.:	Is it Okay To Leave A Message?
	( )	❑ Yes ❑ No	( )	❑ Yes ❑ No

Street Address:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone No.:
		( )

Referred To Clinic By (Please Check One Box):			❑ Doctor	❑ Friend	❑ Family	❑ Insurance Plan
❑ Hospital	❑ Close To Home/Work	❑ Internet	❑ Yellow Pages		❑ Other:	

Please Give Your Photo I.D. To The Receptionist

I GIVE PERMISSION TO DISCUSS MY MEDICAL DIAGNOSIS, TREATMENT, TEST RESULTS, AND APPOINTMENTS WITH:
(PLEASE CHECK ONE BOX)

☐ Anyone in my family ☐ Please **do not** release any information to anyone ☐ Only the following people:

1. Name of Friend or Relative:	Relationship To Patient:	Home Phone No.:	Work or Cell Phone No.:
		( )	( )
In The Case Of An Emergency, May We Release Information To This Person?	❑ Yes ❑ No	May We Leave A Message?	❑ Yes ❑ No

2. Name of Friend or Relative:	Relationship To Patient:	Home Phone No.:	Work or Cell Phone No.:
		( )	( )
In The Case Of An Emergency, May We Release Information To This Person?	❑ Yes ❑ No	May We Leave A Message?	❑ Yes ❑ No

3. Name of Friend or Relative:	Relationship To Patient:	Home Phone No.:	Work or Cell Phone No.:
		( )	( )
In The Case Of An Emergency, May We Release Information To This Person?	❑ Yes ❑ No	May We Leave A Message?	❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of Friend or Relative (Not Living at Same Address):	Relationship To Patient:	Home Phone No.:	Work or Cell Phone No.:
		( )	( )
In The Case Of An Emergency, May We Release Information To This Person?	❑ Yes ❑ No	May We Leave A Message?	❑ Yes ❑ No

The Above Information Is True To The Best Of My Knowledge. I Understand That I Am Financially Responsible For Any Balance.

Patient or Guardian Signature *Date*

Witness Signature *Date*

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PATIENT HEALTH HISTORY

Dr. Tammy Wu, Board Certified Plastic Surgeon
Dr. Calvin Lee, Board Certified General Surgeon

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Patient Name: _____ **Age:** _____
(Last) (First) (MI)

Primary Care Dr.: _____ **Patient Occupation:** _____

Reason for Seeing the Doctor Today:_____

How did you hear about our practice? _____

List Any Medications You Are Taking, Including Non-Prescription, Vitamins, and Herbs:

_____

Drug Allergies and Reactions, including Latex and Tape:

_____

List Previous Surgeries or Major Illnesses, including Dates:

_____

Social History:
Alcohol (Type and Amount per Week) _____ Any drug History: _____
Smoking (Type & Amount per Day) _____ Date Quit: _____
Height_____ Weight_____

Patient Medical History:

	Yes	No		Yes	No		Yes	No
Anemia			Glaucoma			Rheumatic Fever		
Arthritis			Heart Disease			Stomach Ulcer		
Asthma			Hepatitis			Stroke		
Bleeding Tendency			High Blood Pressure			Tuberculosis		
Cancer			Kidney Disease			Thyroid Disorder		
Diabetes			Mitral Valve Prolapse			AIDS Or HIV+		

Review of Symptoms: Do You Presently Have, or Had Within the Past Year:

	Yes	No		Yes	No		Yes	No
Bloody Stool			Easy Bleeding			Seizures		
Chest Pain			Easy Bruising			Skin Rash		
Chronic Cough			Fever Blisters			Sleep Apnea		
Chronic Diarrhea			Jaundice			Swollen Feet/Ankles		
Dry Eyes			Joint/Muscle Pain			Swollen Lymph Nodes		
Depression			Rapid Heart Beat			Weight Changes		

Women Only: For All Breast Consultations

	Yes	No	Have You Had/Or Plan To Have Any:	Yes	No	Date
Do You Do Regular Breast Self-Examinations?			Chemotherapy or Radiation?			
Have You Had a Breast Lump or Discharge?			Most Recent Mammogram?			
What is your Bra Size?			Do You Breast Feed?			

Family History: (*Relatives only please*)

	Yes	No	**Who?**		Yes	No	**Who?**
Breast Cancer				Heart Disease			
Melanoma				High Blood Pressure			
Stroke				Depression			
Diabetes				Kidney Disease			

I Verify That The Above Information Is True To The Best Of My Knowledge.

X_____ _____
Patient or Guardian Signature *Date*

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Consent for Photographs or Digital Imaging

In connection with, and in consideration of medical services for which I have been receiving, or am about to receive from Tammy Wu, MD and/or Calvin Lee, MD; I hereby **consent that clinical photographs or digital imaging may be taken of me, or parts of my body**, under the following conditions:

- The photographs/digital imaging **shall be used for medical record purposes** and shall remain the property of Tammy Wu, MD and Calvin Lee, MD.
- The photographs/digital imaging shall be taken only with the consent of my physician and under such conditions and at such times as may be approved by him/her.
- The photographs/digital imaging shall be taken by my physician or by a photographer approved by my physician.

Series of Pictures Pertaining To:

_____

_____
Patient Signature Date

_____
Witness Signature Date

Medical Education, Teaching, and Research Authorization Form

If, in the judgment of my physician, medical research, education or science will be benefited by their use, my clinical photographs and information relating to my case may be published and republished. Either separately or in connection with each other in professional journals or medical books, or used for any other ethical professional purpose which my physician may deem proper in the interest of medical education, knowledge or research. Provided, that it is specifically understood that in any such publication or use, I shall not be identified by name.

Your Rights:

- I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.
- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I have a right to receive a copy of this authorization. If this box [ ] is checked, a copy of this authorization was requested and received. Initials_____
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to 2336 Sylvan Avenue, Modesto, CA 95355.
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.

Series of Pictures Pertaining To:

_____

_____
Patient Signature Date

_____
Witness Signature Date

Date of Expiration: [ ] 100 years [ ] other: _____

Continue on back

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RECEIPT OF NOTICE OF PRIVACY POLICIES WRITTEN ACKNOWLEDGEMENT FORM

I have received a copy of Surgical Artistry's Notice of Privacy Practices.

_____

Patient Signature Date

_____

Witness Signature Date

Smoking, Second-Hand Smoke Exposure, Nicotine Products (Patch, Gum, Electronic Cigarettes, Nasal Spray):

Patients who are currently smoking, use tobacco products, or nicotine products (patch, gum, electronic cigarettes, or nasal spray) are at a greater risk for significant surgical complications of skin dying, delayed healing, and additional scarring**.** Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smokers may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication. Please indicate your current status regarding these items below:

☐ I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.

☐ I am a smoker or use tobacco / nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

***It is important to refrain from smoking at least 6 weeks before surgery and until your physician states it is safe to return, if desired*.**

_____

Patient Signature Date

_____

Witness Signature Date

Continue on back

Tammy Wu, MD Board Certified Plastic Surgeon
Calvin Lee, MD Board Certified General Surgeon, Acupuncturist

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PRIVACY POLICIES

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and hea1thcare operations (TPO). To that end, our practice and its physicians and staff will--

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will--
  - ✓ Implement' reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will--
  - ✓ Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
  - ✓ Not disclose PHI data unless the patient (or his/her authorized representative) has properly authorized the release or the release is otherwise authorized by law.
  - ✓ Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will-- permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
  - ✓ Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.
- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action. up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

Please let our staff know if you would like another copy of our privacy policies.

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2336 Sylvan Avenue, Suite C
Modesto, California 95355
Telephone (209) 551-1888
Fax (209) 551-5662
www.SurgeryToday.com

T. Tammy Wu, MD – Board Certified Plastic Surgeon
Calvin Lee, MD – Board Certified General Surgeon

Acupuncture · Botox · Breast · Cancer · Liposuction · Facelift · Eyelids/brows · Obagi skin care · Spider Veins

NOTICE OF FINANCIAL RESPONSIBILITY

Thank you for choosing Surgical Artistry. Please take a moment to review our financial policy. A clear understanding of our financial policy is an important part of our professional relationship. The patient is responsible for the timely payment of their account. The payment must be made in full the same day the procedure is performed or purchase is made. Surgery payment is due in full two weeks before the date of the surgery. Please let us know if you would prefer to discuss the financial aspect of your surgery, purchase, or procedure privately, and not in front of your caretaker or companion.

The payment options for your surgery, purchase, or procedure are as follows: cash, personal or cashiers checks, money orders, credit cards, and/or third-party financing plans. If a personal check does not clear, there is a minimum charge of $25 per bounced check fee, plus 10% processing fee on the total amount of the written check.

I, _____, understand that I will have services rendered by Dr. Tammy Wu / Dr. Calvin Lee. I understand that I remain financially responsible for any charges not paid in accordance to this authorization and any additional fees due to late payment. Please feel free to call the office at (209) 551-1888 if you have any other questions or concerns. Thank you for your understanding.

By signing below, I attest that the following statements are true:

I have read the above information.
I understand my financial obligations.
I have had my questions answered satisfactorily.
The details of the above information have been explained to me satisfactorily by the Surgical Artistry office staff.

_____ _____
Patient Signature Date

_____ _____
Witness Date

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NOTICE TO CONSUMERS:

I understand that the Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov.

Board Certification

Medical specialty certification in the United States is a voluntary process. While medical licensure sets the minimum competency requirements to diagnose and treat patients, it is not specialty specific. Board certification demonstrates a physician's exceptional expertise in a particular specialty and/or subspecialty of medical practice.

American Board of Medical Specialties
Higher standards. Better care.®

Dr. Tammy Wu, a graduate of Brown University Medical School is **board certified by the American Board of Plastic Surgery (ABPS).** This is the *only* board recognized by the American Board of Medical Specialties to certify a surgeon in plastic surgery of the face and of the entire body. Certification by the ABPS is "the gold standard" for plastic surgeons because it signifies that the surgeon has had formal training in an accredited plastic surgery residency program. She is also a member of the American Society of Plastic Surgeons.

Dr. Calvin Lee, a graduate of Brown University Medical School is **board certified by the American Board of Surgery (ABS)**. His acupuncture credentials are from Stanford University.

_____ _____
Patient Name Date

_____
Patient Signature

_____ _____
Witness Date

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I, _____, understand that Dr. Tzuying Tammy Wu, MD and Calvin Lee, MD, of Tzuying Tammy Wu, MD, Inc, are not Medicare providers and have "opted-out" completely. As a result, any services rendered by Dr. Wu or Dr. Lee cannot be submitted to Medicare, and Medicare will not reimburse for services of a non-Medicare provider.

I understand the above statement. I understand that if I choose to have him/her render services and/or perform procedures and/or consultations, I cannot submit my claims to Medicare for the above stated services, and I will not be reimbursed by Medicare for the services, consultations, or procedures.

I understand that I will be financially responsible for all services rendered by Dr. Wu and/or Dr. Lee.

If my primary insurance is Medicare, I will let the office staff know
Initials: _____

Patient Name:_____ Date:_____

Patient Signature:_____ Date:_____

Witness:_____ Date:_____