

Issaquah Plastic Surgery
Kimberly K. Lu, M.D.

1505 NW Gilman Blvd, Suite 4
Issaquah, WA 98027

Referring Doctor: _____

Thank you for choosing our office. In order to serve you properly, PLEASE PRINT the following information.				
Name:		Nickname:	Today's date	
Address:		City/State	Zip	Chart #
AGE:	SSN:	Birthdate:	Marital Status:	Gender:
Home Ph:		May we contact you here?	May we leave a message ?	
		YES	NO	YES
Work Ph/Ext :		YES	NO	YES
Cellphone:		YES	NO	YES
Pager:		YES	NO	YES
Fax:		YES	NO	YES
Email:		YES	NO	YES
Occupation:		Employer:		
Address:				
Spouse's Name, Occupation and Employer				
Emergency Contact Name:			Relationship:	
ER Contact Home Ph:		ER Contact Work Ph:		
<u>If patient is a minor:</u>	Father's Name:		Work Phone	
Father's Employer:				
Mother's Name:		Work Phone:		
Mother's Employer:				

COPAYS FOR OFFICE VISITS OR OFFICE PROCEDURES ARE REQUIRED AT THE TIME OF THE APPOINTMENT. FEES FOR COSMETIC SURGERY ARE DUE IN FULL TWO WEEKS PRIOR TO DATE OF SURGERY.

Primary Insurance Co:		
Insured Party:	ID No:	Group No:
Ins Company Address:		
Secondary Insurance Co:		
Secondary Insured Party:	ID No:	Group No:
Ins Company Address:		

PLEASE PROVIDE COPIES OF INSURANCE CARDS

OVER

MEDICAL INFORMATION

PATIENT NAME: _____

REASON FOR OFFICE VISIT TODAY (PLEASE BE SPECIFIC) _____

REFERRED BY (NAME OF PHYSICIAN OR FRIEND) _____

IF INJURED, DATE OF INJURY _____ **DID THIS OCCUR AT WORK?** _____

HAVE YOU SEEN DR. LU BEFORE? _____

IF SO, WHEN? _____

NAME OF USUAL PHYSICIAN _____

PAST SURGERY _____

KNOWN MEDICAL PROBLEMS (IF NONE , WRITE NONE) _____

DO YOU SMOKE CIGARETTES OR USE TOBACCO PRODUCTS? YES() NO()

HAVE YOU BEEN TESTED FOR THE HIV (AIDS) VIRUS? YES() NO()

RESULTS _____ **DATE OF TEST** _____

TO YOUR KNOWLEDGE HAVE YOU BEEN EXPOSED TO HIV? YES() NO()

I HEREBY AUTHORIZE DR. LU OR THE OFFICE STAFF TO TAKE AND MAINTAIN PRE & POST OPERATIVE PHOTOGRAPHS AS A PART OF MY MEDICAL CHART.

SIGNATURE OF PATIENT OR GUARDIAN _____ **DATE** _____

PATIENT NAME _____

DATE _____

Medication ALLERGIES: please check

_____ **I have no medication allergies**

_____ **I have medication allergies. Please list and describe what happens:**

What medications do you take? (include aspirin, non prescription medications, vitamins and natural pathic medications)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Other:

Assignment and Release

I hereby irrevocably authorize my insurance company/fund to pay benefits for services directly to Kimberly K. Lu, M.D. if I have not paid in full myself. Furthermore, I understand **that I am financially responsible for any amount not paid by my insurance company.** I also authorize Dr. Lu to release any information required to process a claim, including but not limited to insurance companies, health care service plans, worker's compensation carriers and government services.

I understand that the office will submit charges to my insurance carrier and that there is a requirement that my portion be paid on the day treatment is rendered. I understand that if I do not have insurance coverage, payment is due in full for any professional services and supplies. Regardless of pending insurance, claims, all accounts are to be finalized within 60 days.

By signing below, I indicate that I have read and understand the above information and release insurance benefits to be paid to Kimberly K. Lu, M.D.

Patient's Signature _____ Date _____

If Patient is a minor:

Parent or Guardian's Signature _____ Date _____

Relationship to minor: _____

Privacy

I understand the Federal Government has placed restrictions on the exchange/release of patient medical information. In cooperation with these new regulations and to facilitate better and more rapid exchange of information, I offer consent to the release of information to other treating physicians or health care providers, hospitals, my insurance company (or other payers). I understand this information may be exchanged via mail, fax, other electronic media (e-mail), telephone or orally. **All attempts will be made to keep this information STRICTLY confidential.**

I have been informed of my medical provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my provider has the right to change the *Notice of Privacy Practices* and that I may contact the office to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Signature _____ Date _____

If Patient is a minor:

Parent or Guardian's Signature _____ Date _____

Relationship to minor: _____