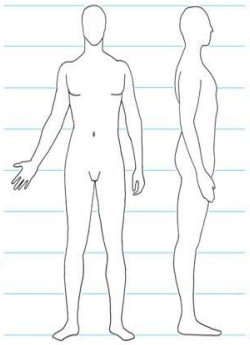
TODD C. RAU, M.D.
PLASTIC SURGERY

Cosmetic intake form

Patient's Last name:		First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one): Single Married Divorced Separated Widowed
Birth date: / /	Age:	Gender:	Social Security #	**E-Mail Address**:		
Street address:		Home phone # ( )		Cell phone # ( )		
P.O. Box:		City:		State:	ZIP Code:	
How did you hear about us?	❑ Dr. _____	❑ Friend who:_____		❑ Website	❑ Other	
WHAT DO YOU DO AT YOUR JOB?						

Reason for Cosmetic Consultation: (Areas of concern)

□ Breast Enhancement	□ Liposuction	□ BOTOX/ Fillers	□ Body Lift
□ Face Lift	□ Eyelid Surgery	□ Nose Reshaping	□ Brow Lift
□ Breast Reduction	□ Ear Reshaping	□ Tummy Tuck	□ Breast Lift



What are your expectations following surgery

1.) _____
2.) _____
3.) _____

IN CASE OF EMERGENCY

Name of local friend / relative:	Relationship to patient:	Home phone # ( )
		Work phone # ( )

COSTS/FEES

Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee if further treatment is needed on the follow up visits.

Initials:_____

The undersigned agrees to pay all charges for medical services rendered and do hereby become reasonable for any uninsured balance.

Initials:_____

Patient Signature:_____**Date:**_____

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DATE:		**NAME**(LAST, FIRST):	
DOB:	**AGE:**	**HEIGHT:**	**WEIGHT:**
WHAT ARE WE SEEING YOU FOR TODAY?			

Medical History (Check all that apply)	
☐ Arthritis	☐ Epilepsy
☐ Asthma	☐ Heart Attack (Year):_____
☐ Bleeding Disorder	☐ Heart Disease
☐ Blood Transfusion	☐ Heart Murmur
☐ Breast Disorder	☐ Hepatitis/AIDS/HIV (circle)
☐ Cancer	☐ High Blood Pressure
Breast(Year)_____	☐ High Cholesterol
Skin(Type)_____	☐ Indigestion/GERD
Other_____	☐ Irregular Heart Rate
☐ Chronic Bronchitis	☐ Keloids/Thick Scars
☐ Congestive Heart Failure	☐ Kidney Disease
☐ Deep VenousThrombosis (DVT)	☐ Pulmonary Embolism
☐ Depression	☐ Recurrent Pneumonia
☐ Diabetes Mellitus	☐ Stroke (Year):_____
☐ Emphysema/COPD	☐ Thyroid Disease

☐ Other illnesses, accidents or injuries (list):

_____

_____

Women Only		
Number of pregnancies	**Number of children:**	
Experienced any recent tenderness, lumps or nipple discharge?	**Yes**	**No**
Date of last Mammogram?	**Bra Cup Size?**	

Previous Surgeries /Plastic Surgeries:

Year	Procedure	Doctor

ARE YOU WILLING TO ACCEPT A BLOOD TRANSFUSION?	☐ Yes	☐ No
IS PATIENT JEHOVAH WITNESS?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, to include vitamins and herbal supplements:

Medication name:	Strength:	Frequency taken:

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Allergies To Medications/Latex/Foods	
Name of the Drug	**Reaction You Had**
☐ **NO KNOWN DRUG ALLERGIES**	

Family Health History		
Major Illnesses/Diseases	**Maternal (Mother)**	**Paternal (Father)**

Social History				
Martial Status (circle one) Single/married/Divorced/Separated/Widowed			**Number Of Children**	
Height: _____ **Weight:** _____				
Exercise	**Yes**	**No**	☐ None ☐ Occasional ☐ Mild (2-3 days per week) Daily vigorous exercise	
Alcohol	**Yes**	**No**	Number of drinks /wk	
Drugs	**Yes**	**No**	Have you ever given yourself street drugs with a needle?	Do you currently use recreational drugs?
Tobacco	**Yes**	**No**	☐ Cigarettes/Pack a day ☐ Chew- #/day:_____ ☐ Pipe- #/day:_____	☐ Cigars-#/day ☐ # of years:_____ ☐ Or year quit:_____
Sex	**Yes**	**No**	If yes, are you trying to get Pregnant?	

Other Problems/Review of Systems		
Check if you have , or have had any symptoms in the following areas to a significant degree and briefly explain.		
☐ Ability to sleep	☐ Ears	☐ Skin
☐ Back	☐ Energy levels	☐ Throat
☐ Bladder	☐ Head/Neck	☐ Weight
☐ Bowel	☐ Intestinal	☐ Recent changes in:
☐ Chest/Heart	☐ Lungs	☐ Other pain discomfort:
☐ Circulation	☐ Nose	

What kind of skin care products are you currently using:

□ Glycolic Acid	□ Vitamin A (Retinol)	□ Soap	□ Toner/Astringent	□ Moisturizer
□ Exfoliating Scrub	□ Mask	□ Eye Cream	□ Sun Screen	□ Other

The above information is true to the best of my knowledge:

Patient Signature: _____ Date: _____

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Notice of Privacy Practices

SUMMARY

The confidentiality of your personal health information, commonly called your medical record, has always been a high priority at Doctor Todd Rau's office. There are a number of reasons that we may need to use this information or release (disclose) it to others. This Notice of Privacy Practices is provided to inform you of the ways that we can use and release information from your medical record**. THIS PAGE IS NOT THE FULL NOTICE OF PRIVACY PRACTICES, PLEASE READ THE ATTACHED DOCUMENT FOR ADDITIONAL INFORMATION.** In addition to our longstanding commitment to protecting your information there are certain obligations that we have under federal law. One of those obligations is to provide you with this Notice.

THINGS EXPLAINED IN THE NOTICE:

- **How we may use and share your health information without your permission to**:
    - provide treatment to you,
    - get paid for the services we provide to you
    - operate our clinics and other facilities
    - make reports to federal, state and local agencies and others when the law requires such reporting
    - make reports or share health information for public health, safety and/or research reasons
- **How we can use and share your health information without your permission, but only if we give you chance to object:**
    - to share information about you to family, friends or others involved in your care or payment for the services you receive
    - to share information about you in case of a disaster to let your family and friends know where you are and your general condition
- **How we can use and share your medical information only with your permission**
- **What your legal rights are under federal privacy laws like your right to:**
    - ask to see and copy your medical information.
    - ask that incorrect or incomplete information in your medical information by corrected
    - ask for a list of the places we have sent you information unless it was sent with your permission, for payment, treatment or health care operations
    - ask that we limit the information we use or share for payment treatment, payment or healthcare operations or the information we share with family members or others involved in your care or payment for your care. We are not required to agree to your request.
    - ask that we communicate with you in a confidential manner
    - ask for a paper copy of the Notice of Privacy Practices at any time
- **How you can file a complaint if you think your privacy rights have been violated**
- **If you would like a full copy of Todd C. Rau's Notice of Privacy Practices, please ask our office staff and we would be happy to provide you a copy. Thank-You.**

TODD C. RAU, M.D.
1467 Ford Street Suite 101
REDLANDS, CA 92373
909-792-1100

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided Dr. Todd Rau's Notice of Privacy Practices:

_____ _____
Signature of Patient or Personal Representative Date

I acknowledge that I was offered a copy of Dr. Todd Rau's Notice of Privacy Practices, but I declined the provided paperwork:

_____ _____
Signature of Patient or Personal Representative Date