De La Cruz Plastic Surgery
2219 Sawdust Road Unit 1203
The Woodlands, TX, 77380
Phone: (832) 520-1844
Fax: (832) 616-3429

PATIENT INFORMATION FORM DATE:_____

Last Name: First Name: Middle Name:

OCCUPATION: EMPLOYER: Date of Birth: Gender: Male / Female

Marital Status: SINGLE / MARRIED / DIVORCED / WIDOW Social Security Number: _____-_____-_____ DRIVER's LICENSE _____

Address 1:

City: State: Zip Code:

Home Phone: Work Phone: Cell Phone: Email:

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Mail

Preferred Delivery Method: ☐ Mail ☐ Electronic Preferred Language:

Race: ☐ Middle eastern ☐ Asian ☐ Black or African American ☐ Latin ☐ White / Caucasian ☐ Other:_____

PRIMARY CARE DOCTOR: _____
Primary Care Doctor Phone Number: _____ FAX No .:_____
PHARMACY: _____ Phone #:_____ FAX No. : _____

EMERGENCY CONTACT INFORMATION

Last Name: First Name:

Patient's Relationship to Responsible Party: Phone:

Address 1:

Address 2:

City: State: Zip Code:

Reason for Initial Consultation: _____

Concerns about your body: P

CIRCLE THE PROCEDURES YOU ARE INTERESTED IN:

Breast Augmentation	Breast Lift	Scarless Breast Lift
Abdominal Etching	4D VASER High-Definiition Liposuction	Brazilian Butt Lift
Abdominoplasty	Umbilical Reconstruction	Labiaplasty/Vaginal Rejuvenation
Facelift	Neck Lift	FACETITE/NECKTITE
Dimple Surgery	OTHER LIPOSUCTION PROCEDURES:	_
OTHER PROCEDURES :		

HIPAA CONSENT: Below, please list anyone you would like to be allowed to receive information regarding your medical care (leave blank if you would not like any additional individuals to have information regarding your care).

1) Name:	Relationship to patient:	Phone Number:
2)Name:	Relationship to patient:	Phone Numner

DISCLOSURES TO FAMILY MEMBERS AND FRIENDS The new government HIPAA regulations require permission from the patient in order for any healthcare professional to speak with family, friends or caregivers regarding your protected health information, except in cases of emergency. The above information is true to the best of my knowledge. I authorize Emmanuel De La Cruz MD/De La Cruz Plastic Surgery to contact my family/friend for any emergencies. I understand that I am financially responsible for any balance. I also authorize De La Cruz Plastic Surgery to release any information required to process my claims and share your medical information with the above listed contacts.

_____ _____

Patient/Guardian signature Date

MEDICAL INFORMATION

Chief Complaint or Chief Concern:
_____

Is this visit related to an injury sustained while at work? ☐ Yes ☐ No

Date of Injury: _____/_____/_____ Height: _____ ft. _____ in. Weight: _____

SMOKING STATUS:

☐ Current Every Day ☐ Current Some Days ☐ Never smoked ☐ Smoker, current status unknown ☐ Former smoker ☐ Unknown

ALCOHOL or DRUG HISTORY:

☐ Alcohol ☐ Cocaine ☐ Marijuana ☐ Methamphetamines/Ecstasy ☐ Heroine ☐ Others: _____

ACTIVE MEDICATIONS: ☐ None

MEDICAL HISTORY: ☐ None

☐ Anemia	☐ Tuberculosis	☐ Heart Disease:_____	☐ Thyroid problems
☐ Aneurysm **Had Surgery**	☐ Cancer :_____	☐ AIDS/HIV	☐ Bleeding Tendency
☐ Aneurysm **NO Surgery**	☐ Diabetes	☐ Stroke	☐ Hepatitis
☐ Asthma	☐ Hypertension	☐ Pacemaker	☐ Renal/Kidney Disease
☐ ANXIETY	☐ DEPRESSION	☐ BIPOLAR DISORDER	☐ Schizophrenia

ALLERGIES: ☐ None

☐ Adhesive Tape	☐ Mild	☐ Moderate	☐ Severe	☐ Latex	☐ Mild	☐ Moderate	☐ Severe
☐ Bee Sting	☐ Mild	☐ Moderate	☐ Severe	☐ Lidocaine / Novacaine	☐ Mild	☐ Moderate	☐ Severe
☐ Betadine (Topical Iodine)	☐ Mild	☐ Moderate	☐ Severe	☐ Mold	☐ Mild	☐ Moderate	☐ Severe
☐ Contrast (Med. Imaging)	☐ Mild	☐ Moderate	☐ Severe	☐ Peanut or other nut	☐ Mild	☐ Moderate	☐ Severe
☐ Dog, Cat, or Animal	☐ Mild	☐ Moderate	☐ Severe	☐ Penicillin	☐ Mild	☐ Moderate	☐ Severe
☐ Dust	☐ Mild	☐ Moderate	☐ Severe	☐ Rubbing Alcohol	☐ Mild	☐ Moderate	☐ Severe
☐ Fruit	☐ Mild	☐ Moderate	☐ Severe	☐ Shellfish	☐ Mild	☐ Moderate	☐ Severe
☐ Grass / Pollen	☐ Mild	☐ Moderate	☐ Severe	☐ Sulfa Drug	☐ Mild	☐ Moderate	☐ Severe

HIPAA COMPLIANCE STATEMENT - THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
At this practice, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION - **By becoming a patient at De La Cruz Plastic Surgery, you are giving consent for De La Cruz Plastic Surgery to use your protected health information for certain activities, including treatment, payment and other health care operations. Sometimes, you may hear these three activities referred to as "TPO"** This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.
YOUR RIGHTS - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.
OUR RESPONSIBILITIES - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.
EXAMPLES OF HOW YOUR INFORMATION IS USED - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.
OTHER NOTICES - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.
FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM - If you have concerns or would like additional information, you may contact the Office Manager.

Signature: (HIPAA Policy) _____ Date:_____

DE LA CRUZ PLASTIC SURGERY ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits. In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original. I ACCEPT THE RIGHT TO PAYMENT.

P**ATIENT CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION** I hereby give my consent for Emmanuel De La Cruz MD, PLLC, A Medical Corporation, to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare options (TPO).* I have the right to review the Notice of Privacy Practices prior to signing this consent. De La Cruz Plastic Surgery reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Emmanuel De La Cruz MD, PLLC, A Medical Corporation's Privacy Officer at his office. With this consent, De La Cruz Plastic Surgery may call my home or another alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent, Emmanuel De La Cruz MD, PLLC, A Medical Corporation may mail to my home or another alternative location, any items that may assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Confidential". I have the right to request that Emmanuel De La Cruz MD, PLLC, A Medical Corporation restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. With this consent, Emmanuel De La Cruz MD, PLLC, A Medical Corporation may use my PHI during Quality Assurance meetings. By signing this form, I am consenting to Emmanuel De La Cruz MD, PLLC, a Medical Corporation's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Emmanuel De La Cruz MD, PLLC, A Medical Corporation may decline to provide treatment to me.

CONSENT FOR PHOTOGRAPHY, VIDEOTAPING OR PUBLICATION I do hereby voluntarily participate and give authorization to appear in filming, photographs, videotaping and/or interviews for De La Cruz Plastic Surgery's public relations and advertising. I do hereby consent to the unlimited use of such product or interview in De La Cruz Plastic Surgery's publications and/or website, news media reports, newspapers, magazine, television or radio, billboard or any type of advertising. I do hereby release De La Cruz Plastic Surgery, its agents and employees from all liability in connection with the above. I waive any right to inspect or approve the finished product or the advertising or other copy that may be used in connection with the above. I hereby consent to the above, without expectation of remuneration to me now or in the future, and this shall be binding upon my heirs, personal representative and assigns. I agree to allow my records to be reviewed by other physicians of De La Cruz Plastic Surgery for the purpose of peer reviews. Before and after photographs are an important evidence as to the success of your operation. Dr. De La Cruz does not use these photographs for any purpose unless he has your permission. However, many patients who are contemplating surgery, find looking at before and after pictures to be very useful. For this reason we would like to have your permission to use these photographs for patient education. Occasionally Dr. De La Cruz uses them for lectures or talks on plastic surgery, to post on our website, or for marketing purposes. **Dr. De La Cruz will only use them if you do not change the (I Allow) below**. Please circle the appropriate option.

I allow/ do not allow…….Dr. De La Cruz to utilize my photographs for educational purposes.

I allow/ do not allow…….my photographs to be used on Dr. De La Cruz's website

I allow/ do not allow…….my photographs to be used for marketing and advertising.

I have read the above statement and allow Dr. De La Cruz to use my before and after photographs for the purposes indicated above.

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES THAT ARE NOT COVERED BY MY INSURANCE COMPANY.

_____	_____	_____
Signature of Patient or Legal Guardian	Patients Name or Legal Guardian Printed	Date

Patient Care Staff Member: _____ Date: _____