Blackhawk Plastic Surgery

Name _____ **Date** _____

Age **Birth Date** **Social Security Number** _____

Address _____ **City** **State** **Zip** _____

Cell Phone **Text message reminders? Y / N** **Cell Phone Carrier** _____

Email _____

Occupation _____ **Employer** _____

Spouse/ _____ **Employer** _____

Nearest Relative not living with you _____ **Phone** _____

How were you referred? _____

If another patient, may we thank them? _____ **Primary MD** _____

Please check your concerns you would like to discuss:

Surgical:

- ☐ Breast Augmentation
- ☐ Breast Lift
- ☐ Breast Reduction
- ☐ Breast Reconstruction
- ☐ Revision of Breast Surgery
- ☐ Labiaplasty
- ☐ Abdominoplasty (tummy tuck)
- ☐ Lower Body Lift
- ☐ Buttock Lift
- ☐ Liposuction/ Aqualipo
- ☐ Arm / Thigh Lift
- ☐ Chin
- ☐ Short Scar Facelift
- ☐ Eyelid
- ☐ Brow Lift
- ☐ Neck Lift
- ☐ Nose Reshaping
- ☐ Other: _____
- ☐ Fat Transfer / Naturalfill (Buttocks, Breast, Face, etc)

Non-Surgical:

- ☐ Age Management Services
- ☐ Hyperpigmentation (sun damage)
- ☐ Facial Redness / Rosecea / Veins
- ☐ Botox/Dysport (wrinkles, excessive sweating)
- ☐ Laser Hair Removal
- ☐ Hair Restoration
- ☐ Skin Laxity
- ☐ Restylane/Perlane/Bellafill (dermal fillers)
- ☐ Skin Care (texture, pores, acne)
- ☐ Ulthera (lift and skin tightening)
- ☐ G-Shot
- ☐ Other: _____

Are you sensitive or allergic to:	Yes	No	Family illness, including breast cancer:
Penicillin			
Lidocaine or other local anesthetic			
General Anesthesia			
Other:_____			

Medical Problems:	Previous Surgery:
Last mammogram: Was it normal?	List any breast disease, biopsy, lump, etc.

Any children? Ages?	Did you breastfeed?	Did you have a c-section?
Do you smoke? How much? If quit, when?	List current medications:	Do you have HIV or Hepatitis?

Have you ever taken:	Yes	No	Have you ever had:	Yes	No
Anti-coagulalant?			Cancer?		
Blood thinners?			Heart or lung trouble?		
Insulin?			Dizziness or fainting?		
Diuretic?			Diabetes?		
Hydrochlorothiazide?			Kidney trouble?		
Sedative/Tranquilizers?			Blood clots, phlebitis?		
Steroids?			High or low blood pressure?		

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Blackhawk Plastic Surgery to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Blackhawk Plastic Surgery's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Ronan will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Blackhawk 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 Blackhawk Plastic Surgery Privacy Officer at [*3600 Blackhawk Plaza Circle Danville, Ca. 94506*].

With this consent, Blackhawk Plastic Surgery may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that 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, Blackhawk Plastic Surgery may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal or Confidential. Thank you cards will not have that designation and may be mailed.

With this consent, Blackhawk Plastic Surgery may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Blackhawk Plastic Surgery 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.

By signing this form, I am consenting to Blackhawk Plastic Surgery'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, Blackhawk Plastic Surgery may decline to provide treatment to me.

I have received a written or emailed copy, or have seen the online version, of Blackhawk Plastic Surgery's Notice of Privacy Practices I have received a written or emailed copy, or have seen the online version, of Blackhawk Plastic Surgery's Notice of Privacy Practices.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

_____ _____
Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____
Date

Authorization and Release for Medical Photographs, Observation of Surgery, and HIPAA Written Acknowledgement

Instructions: This is a consent document that has been prepared to help inform you concerning permission to take photographs and/or videotapes and to use these images for the purpose as defined within this consent document. It is also designed to inform you concerning permission to allow observation of surgery or procedures by professional visitors.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

Introduction: Medical photographs and/or videotapes may be taken before, during, or after the surgical procedure or treatment. Consent is required to take such images.

Additionally, patient may consent to release these medical photography and/or videotapes for a stated purpose. Your name will not be released. Body photographs do not include the face.

Professional visitors may request to view the work of the surgeon. These professional typically include other physicians or residents that want to learn or and equipment or sales representative from a company interested in plastic surgery. These visitors do not participate in the surgery. You would be informed ahead of time if there were to be an observer. You could refuse then if desired.

Consent to take photographs
I hereby authorize Drs. Ronan, and/or his associates or licensees to take pre-operative, intra-operative, and post-operative photographs, images, etc.

Consent for release of photographs
I hereby authorize Drs. Ronan, and/or his associates or licensees to use pre-operative, intra-operative, and post-operative photographs, images, etc. for professional medical purposes deemed appropriate including but not limited to showing these images on television, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups. I understand that I will not be entitled to monetary payment or any other consideration as a result or any use of these images and/or my interview.

Consent for observation of surgery
I hereby consent to allow professional visitors to observe my surgical procedure / treatment under the direction of Dr. Ronan.

Consent for Medical Research
I hereby authorize Dr. Ronan, and/or his associates or licensees to use removed/discarded tissue for medical research.

Receipt of Notice of Privacy Practices Written Acknowledgement Form
I have received a written or emailed copy, or have seen the online version, of Blackhawk Plastic Surgery's Notice of Privacy Practices.

_____	_____
Patient Signature	Date
_____	_____
Print Patient Name	Witness Signature