Name: DOB: / /

Address:

Phone #: Home Work

Cell Email

WASHINGTONIAN PLASTIC SURGERY

Dr. Navin K. Singh

Emergency Contact Name and #:

Only provide contact information where we can contact you or leave a message

Age: Gender: Height: Occupation:

Marital Status: Number of Children: Spouse Name:

Medical Conditions: (Check all that apply)

- ◯ Diabetes
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ Heart Disease
- ◯ Mitral valve Prolapse
- ◯ Stroke
- ◯ Dry Eyes
- ◯ Depression/Anxiety
- ◯ Eating Disorder
- ◯ Thyroid Disease
- ◯ Seizures
- ◯ Recent Breast Feeding
- ◯ Anemia
- ◯ Cancer
- ◯ Chemotherapy
- ◯ Radiation
- ◯ Cold Sores
- ◯ Keloids
- ◯ Bleeding/Clotting Problems
- ◯ Sleep Apnea
- ◯ Acid Reflux/Heart burn
- ◯ Problems with Anesthesia
- ◯ Hepatitis
- ◯ HIV

Allergies to Medications, Latex, Iodine, etc.:

Do you smoke? ◯ Never ◯ Social Smoker ◯ Ex- Smoker ◯ Current Smoker

What is your ..... Current Weight Highest weight ever Lowest weight ever

How many alcoholic drinks in a typical week?

Previous Surgery and Cosmetic Surgery: (appendectomy, c-section, gallbladder, breast augmentation, etc.)

Name of Procedure	Date of Surgery	Hospital

Please list all medications: (Rx Meds, Birth Control, Diet Pills, Herbal Preparations etc.)

Name of Medication	Dose	Frequency

Procedures or Products of interest to you: (Check all that apply)

- ◯ BoTox / Dysport
- ◯ Filler Juvederm/Restylane/Voluma
- ◯ Laser Treatments
- ◯ Ulthera Skin Tightening
- ◯ Chemical Peel
- ◯ Micro/Dermabrasion
- ◯ Liposuction / Laser Lipo
- ◯ Breast Augmentation
- ◯ Breast Lift / Reduction
- ◯ Tummy Tuck
- ◯ Brazilian Buttock Lift
- ◯ Gynecomastia
- ◯ Eyelid Lift
- ◯ Brow lift
- ◯ Facelift/ Neck lift
- ◯ Chin Lipo/ Chin implant
- ◯ Nose/Rhinoplasty
- ◯ Fat Grafting
- ◯ Labiaplasty
- ◯ Otoplasty/Ear Pinning
- ◯ Body Lift
- ◯ Mole Removal
- ◯ Other

Referred By:

I learned about your practice from:

Internet: ◯ Google ◯ iPhone App ◯ YouTube ◯ Yelp ◯ Real-Self
◯ Television ◯ Love Your Look ◯ Looking Your Best ◯ Airline Mileage

Magazine: ◯ Washingtonian Magazine ◯ Capitol File Magazine
◯ Bethesda Magazine ◯ Northern Virginia Magazine

Radio: ◯ Hot 99.5 ◯ Mix 107.3

Office use only:

Authorization for Examination and Notification of Financial & Privacy Policies

Your Attestation and Consent for Examination:
I certify that the above represents my complete and accurate medical and psychiatric medical conditions and that I, or my guardian, consent to examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

Protecting Your Privacy Insurance Processing:
I hereby consent to the use of my protected health information including my demographic information, collected from me and created or received by Washingtonian Plastic Surgery Associates or another providing treatment to me, obtaining payment for my plastic surgery bills or to conduct health care operations. This protected health information relates to my past, present, or future physical or mental conditions and identifies me. I also understand that Washingtonian Plastic Surgery will make every effort to assure that my information is used only as I authorize. However, once my information is disclosed, it may no longer be protected by federal and state privacy laws.
I have the right to review the practice's Notice of Privacy Practices, which can be provided to me, prior to signing this document. This authorization has no end date, unless I cancel this authorization, which I may do at any time by mailing or faxing my written request to the office. I understand that if I cancel this authorization, the cancellation would affect only future disclosure of my information, photographs, and images. If Washingtonian Plastic Surgery Associates has already taken action based on my authorization at the time of my cancellation, my cancellation will not affect that disclosure.

Payment Policy:
Payment is due at time of services and is non-refundable. Washingtonian Plastic Surgery Associates and Dr. Singh do not participate with insurance plans, and the ultimate responsibility for all and full financial payment rests with me. I am also responsible for all costs of collection. I authorize payments of medical benefits directly to the doctor for services provided to me. Some cosmetic surgery visits may be free, but if there is a part that I wish to submit for potential insurance coverage, then that visit must be billed and I am responsible for all co-pays, deductibles, and final charges.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are performed. By signing this form, I am irrevocably consenting to allow Washingtonian Plastic Surgery to use and disclose my protected health information to any credit card entity, bank, or Financing Company when they request such information to process an account and assist with payment. I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete follow-up care and follow-up interaction to address any issues that might arise.

Photo Privacy Policy:
If photos are taken at my request for my medical chart and can identify me, they will be maintained confidentially. I understand that photography is a useful part of planning/evaluating cosmetic or reconstructive surgery and authorize the taking of photographs or videos at the discretion of my surgeon.

Review:
I authorize the office to contact me via email about my health and about relevant plastic surgery issues.
A copy of this authorization shall be considered as valid as the original. I have read this in an unrushed fashion, had my questions answered, and understood this agreement, which will be effective from the date my care started.

Patient's Signature: ..... **Date:** .....