JOHN LOMONACO, M.D., F.A.C.S.
PLASTIC AND RECONSTRUCTIVE SURGERY

PATIENT INFORMATION

Patient Name: ________________________________ **Date**: ____________

Address: ____

City: ___________________________________ **State**: ___________ **Zip**: _____________

Date of Birth: ____________ **Age**: _________ **Sex**: ________ **Marital Status**: ________

Height: ________ **Weight:** _______ **Social Security #:**____________________________

Telephone: _______________________________ **Email:**____________________________

Drivers License Number: ___________________________________ **State:** ___________

Employed By: ____

How Did You Hear About us? (Circle)

Friend Internet ObesityHelp.com

Nu-Image Other/website ______________________

What would you like to speak with the doctor about?

Abdominal procedure Breast procedure Facial procedure

Hand surgery Skin care Restylane or Botox

Burn Scar care Wound/incision problem

Other ____

Your Medical Insurance Company: ____

Type of plan (Circle One)

PPO **POS** **HMO** **EPO** **Don't know**

***Please provide us with your insurance card if your care will be a covered expense. ***

1009 Missouri St ◆ Houston, Texas 77006◆ Telephone (713) 526-5550◆ Fax (713) 526-5563

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Health Questionnaire

Name (printed):__________________________

What would you like to discuss with the doctor today?

____

____

Do you currently have or have had any medical problems? Please list all.

____

____

Have you ever been pregnant? Yes No Pregnancies ____ Deliveries _____

Have you ever had a Mammogram? Yes No If so, when & why?__________________________

Have you ever had a blood clot (also called DVT) or pulmonary embolism? Yes No

Do you have any blood clotting disorders? Yes No

Do any relatives have blood clotting disorders? Yes No

Any recent or expected travel or trips over 3 hours? Yes No

Have you received a blood transfusion in the past? Yes No If yes, when __________________

Have you had any prior surgery? Please list the procedure and the year it was done.

SURGERY	MONTH/YEAR
____	_______________
____	_______________
____	_______________
____	_______________

Do you regularly take medications? If so please list:

____

Current Birth Control? PILL PATCH INJECTION IUD TUBAL OTHER___________ NONE

Are you allergic to any medications? Please list all.

____

Do you smoke or use ANY form of nicotine? Yes No **How much? _______________________**
Any prior nicotine use? Yes No **For how long? ____________ When: _______________________**

Patient Signature_________________________________ Date: _______________________

All of your responses are a part of your medical record and will be treated with the HIPPA privacy guidelines that pertain to this practice.

JOHN LOMONACO, M.D., F.A.C.S.
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Patient Name:

Date:

Patient Receipt of Privacy Practices – Doctor's Copy

I, _________________________________, acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

____
Signature

____
Date

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John LoMonaco, M.D., F.A.C.S.
Plastic and Reconstructive Surgery

Notice of Privacy Practices – Patient Copy

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FEDERAL LAW REQUIRES THAT PHYSICIANS PROVIDE THEIR PATIENTS WITH A NOTICE OF HOW THEIR MEDICAL INFORMATION MAY BE USED.

WE DO NOT SELL OR IN ANY WAY PROVIDE ANY PERSON OR COMPANY WITH INFORMATION ABOUT YOU FOR ANY PURPOSE OTHER THAN YOUR MEDICAL CARE.

WE STRIVE TO RELEASE ONLY THE MINIMUM NECESSARY INFORMATION ABOUT YOU FOR THE INTENDED PURPOSE.

YOUR PHOTOGRAPHS MAY BE TAKEN AS PART OF THE CONSULTATION PROCESS. THEY ARE NEVER USED OUTSIDE OF THIS OFFICE FOR ANYTHING OTHER THAN YOUR CARE, WITHOUT A WRITTEN AUTHORIZATION FROM YOU.

NO INFORMATION IS SENT TO ANY COMPANIES FOR MARKETING PURPOSES. YOU HAVE THE RIGHT TO OPT OUT OF ANY MAILINGS OR OTHER NOTICES FROM OUR PRACTICE IF YOU SO CHOOSE.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ONLY THE TYPES OF DISCLOSURE RELEVANT TO THIS PRACTICE ARE INCLUDED. A FULL LIST OF DISCLOSURES IS AVAILABLE FROM OUR PRIVACY OFFICER AND IS AVAILABLE FOR YOUR REVIEW.

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Notice of Privacy Practices – Patient Copy

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Our Mission:

We respect your right to privacy and understand that your medical information is personal to you. Your personal health information is confidential and this notice is intended to help you understand how our practice uses and discloses your personal health information and what rights you have with respect to your medical information.

How We May Use and Disclose Your Information
The following describes how our practice is permitted by law to share your personal health information with others in order to provide you with medical care.

Medical Treatment. We may need to share information about you in order to provide medical care to you. For example, we may share information with other physicians, nurses or healthcare professionals entering information into your medical records relating
to your medical care and treatment.

Payment. We may need to disclose information about the treatment, procedures or care our practice provided to you in order to bill and receive payment for services we provided. We may share this information with you, an insurance company or any third party responsible for payment.

Healthcare Operations. In order to help us run our practice more efficiently and provide better patient care, we may use and disclose your personal health information to Business Associates who need to use or disclose your information to provide a service for our medical practice.

If Required by Law. We will disclose medical information related to you if required to do so by state, federal or local law.

To Avert Serious Threat to Health or Safety. If our practice believes, in good faith, that a use or disclosure of your medical information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, we may disclose your medical information.

Worker's Compensation. We may release medical information about you for work-related illness or injury for workers' compensation or other related programs.

Health Oversight Activities. Your personal health information may be disclosed to federal, state or local authorities as part of an investigation or government activity.

Law Enforcement. We may disclose your personal health information to law enforcement individuals if we are required to do so by law. We may also disclose medical information about you in compliance with a court order, warrant or subpoena or summons issued by the court.
Other uses and disclosures will be made only with your written authorization and you may revoke your authorization at any time.