MICHAEL J. SUNDINE, M.D., F.A.C.S., F.A.A.P.
Certified by the American Board of Plastic Surgery
Facial Aesthetic-Cosmetic-Craniofacial Surgeon-Reconstructive-Pediatric Plastic Surgery

Reason for Consultation _____ Date _____
(Facelift, Brow/Forehead Lift-Eyes, Nose (Rhinoplasty)-Breast Augmentation, Facial Rejuvination-etc. Nevus -Cleft Lip-Otoplasty-Hemangioma-Laser-Craniofacial-Cosmetic Procedures/Treatments)

Patient Information

Primary Language _____ Do you need a translator _____yes _____no

Name _____ Date of Birth _____ Age _____
Mr. Mrs. Ms. Miss Dr.

Address _____ Home # ( ) _____

City _____ State _____ Zip _____ Cell # ( ) _____

E-Mail Address _____ Voicemail ( ) _____

May we email you updates or specials? Yes___No_____

May we leave a voicemail message ___yes _____no
May we text you appointment reminders ___yes ___no
Number to text to: _____

Responsible Party/Parent/Guardian: Employment Information (Responsible Person Employment Information)

Parent/Guardian/Responsible Party Name: _____
Phone: _____
Address (if different from above:) _____
City _____ State _____ Zip _____

Employed by _____ Work # ( ) _____

Business Address _____

City _____ State _____ Zip _____

Marital Status(of Patient) Married___ Single___

Spouse Name _____ Cell # ( ) _____

Employed by _____ Work # ( ) _____

Business Address _____

City _____ State _____ Zip _____
May we contact this person? _____Yes _____No

Name and Address of Nearest Relative Not Living with You

Name _____ Relationship _____
Mr. Mrs. Ms. Miss Dr.
Address _____ Phone # ( ) _____

City _____ State _____ Zip _____
May we contact this person? Yes_____ No_____

Referral Information

Referred by _____ Phone # ( ) _____

Address _____

City _____ State _____ Zip _____

May we contact this person Yes_____ No_____

PATIENT/GUARDIAN INITIALS_____

FOR INSURANCE CASES ONLY:

SUBSCRIBER NAME: _____

INSURANCE: IF YOU HAVE AND ID CARD FOR INSURANCE, PLEASE HAND IT TO THE RECEPTONIST TO COPY

Name of Insurance Company _____ Phone ( ) _____

Address _____ City, State _____

Zip _____ ID Information (Policy #, Group #, etc.) _____

DR. SUNDINE IS CONTRACTED WITH VERY FEW INSURANCE COMPANIES. WE WILL REVIEW YOUR INSURANCE AND LET YOU KNOW PRIOR TO SERVICES IF DR. SUNDINE IS CONTRACTED FOR YOUR CURRENT PLAN.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL OF MY MEDICAL BILLS INCURRED, NOT MY INSURANCE COMPANY OR OTHER THIRD PARTY. ANY BALANCE THAT IS NOT COVERED BY INSURANCE (FOR INSURANCE CASES) WILL BE MY RESPONSIBILITY. I UNDERSTAND THAT DR. SUNDINE MAY NOT BE CONTRACTED BY BY MY INSURANCE CARRIER, AND HAVE BEEN INFORMED SO BY DR. SUNDINE OFFICE STAFF, PRIOR TO AND OR AT MY CONSULTATION. I UNDERSTAND THAT DR. SUNDINE OR HIS STAFF HAVE NO RESPONSIBILITY OR CONTORL OF WHAT MY INSURANCE COMPANY REIMBURSES, AND I WILL NEED TO SEEK OUT MY CUSTOMER SERVICE REPRESENTATIVE WITH MY INSURANCE COMPANY PRIOR TO ANY ENCOUNTERS, APPOINTMENTS, OR SERVICES TO HAVE EXPLAINED TO ME MY INSURANCE BENEFITS, AND MAKE SURE ANY AND ALL AUTHORIZATIONS ARE IN PLACE PRIOR TO ANY SERVICES PROIVDED BY DR. SUNDINE OR HIS ASSOCIATES. I HEREBY AUTHORIZE MICHAEL J. SUNDINE, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS OR OTHER THIRD PARTIES CONCERNING THIS ILLNESS. I HEREBY IRREVOCABLY ASSIGN TO MICHAEL J. SUNDINE, M.D. ALL PAYMENTS FOR MEDICAL SERVICE RENDERED BY MICHAEL J SUNDINE MD. Inc. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____

_____ Date _____

Signature of Financially Responsible Person

Primary Care Doctor _____ Phone # ( ) _____

His/Her Address _____

City _____ State _____ Zip _____

Present Illness:

Description _____

Onset _____

Severity of the problem (Scale of 1-10) _____

Location initially, Sites of recurrence _____

Symptoms, preceding and associated _____

How long has the problem lasted? _____

Previous therapy _____

Past History:

Do you have any chronic medical problems?

☐ Hypertension	☐ Diabetes Mellitus	☐ Cancer
☐ Heart Disease	☐ Kidney Disease	☐ HIV or AIDS
☐ Heart Failure	☐ Seizures	☐ Bleeding Problems
☐ Heart Attack	☐ Liver Disease	☐ Stroke
☐ Emphysema	☐ Hepatitis	☐ Ulcers
☐ Asthma	☐ High Cholesterol	☐ Sleep Apnea
☐ Deep Venous Thrombosis	☐ Pulmonary Embolism	☐ Other _____

PATIENT/GUARDIAN INITIALS_____

Please list all prior operations: **Date** **List any complications**

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____
4. _____ _____ _____
5. _____ _____ _____

Please list ALL medications you are taking, include over the counter medications (eg. Aspirin, Motrin, etc.), vitamins, and herbal remedies (Echinacea, Fish Oil, etc.).

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

List any allergies to medications and describe the reactions.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Family History-Do you have any family history of medical problems?

☐ Hypertension	☐ Diabetes Mellitus	☐ Cancer
☐ Heart Disease	☐ Kidney Disease	☐ HIV or AIDS
☐ Heart Failure	☐ Seizures	☐ Bleeding Problems
☐ Heart Attack	☐ Liver Disease	☐ Stroke
☐ Emphysema	☐ Hepatitis	☐ Other _____

Social History-

Have you ever smoked cigarettes? _____ Yes _____ No. If yes, please state the year started _____

How many packs per day did (do) you smoke? _____

If you are a former smoker, state the year you stopped _____

Alcohol Consumption: Never _____ Rare _____ Moderate _____ Heavy _____

Did you ever drink heavily in the past? Yes _____ No _____

Do you ever use drugs? Yes _____ No _____ Type _____ Frequency _____

Occupation _____ Marital Status _____

Height: _____ Weight_____

PATIENT/GUARDIAN INITIALS_____

Review of Systems: Do you have any of the following conditions, illnesses, or symptoms?

General

☐ Chills	☐ Fevers	☐ Loss of sleep
☐ Weight loss	☐ Sweats	

Eye, Ear, Nose, and Throat

☐ Bleeding gums	☐ Blurred vision	☐ Crossed eyes
☐ Difficulty swallowing	☐ Double vision	☐ Earache
☐ Ear discharge	☐ Hayfever	☐ Hoarseness
☐ Loss of hearing	☐ Nosebleeds	☐ Persistent cough
☐ Ringing in ears	☐ Sinus problems	☐ Vision-flashes, halos

Cardiovascular

☐ High blood pressure	☐ Heart attack	☐ Angina/chest pain
☐ Irregular heart beat	☐ Heart murmur	☐ Heart failure
☐ Pacemaker	☐ Swelling of ankles	☐ Varicose veins

Respiratory

☐ Abnormal chest x-ray	☐ Asthma	☐ Bronchitis
☐ Emphysema	☐ Recent chest infection	☐ Shortness of breath
☐ Shortness of breath at night	☐ Shortness of breath on exertion	☐ Cough
☐ Cough	☐ Cough with sputum	☐ History of tuberculosis

Gastrointestinal

☐ Poor appetite	☐ Bloating	☐ Bowel changes
☐ Constipation	☐ Diarrhea	☐ Excessive hunger
☐ Excessive thirst	☐ Gas	☐ Heartburn
☐ Hemorrhoids	☐ Hepatitis	☐ Hiatal hernia
☐ Indigestion	☐ Jaundice	☐ Nausea
☐ Rectal bleeding	☐ Stomach pain	☐ Ulcers
☐ Vomiting	☐ Vomiting blood	

Genitourinary

☐ Blood in urine	☐ Frequent urination	☐ Lack of bladder control
☐ Painful urination	☐ History of kidney disease	☐ History of urinary disease

Musculoskeletal

☐ Arthritis	☐ Rheumatoid arthritis	☐ Herniated disc
☐ Sciatica	☐ Neck problems	☐ Back problems
☐ Leg problems	☐ Arm problems	

Endocrine

☐ Diabetes	☐ Thyroid disease	☐ Taken steroids

PATIENT/GUARDIAN INITIALS_____

Hematologic/Oncologic/Infectious

☐ Bleeding tendency	☐ Easy bruising	☐ Anemia
☐ Sickle cell disease	☐ Blood clots in legs	☐ Blood clots in lungs
☐ Radiation therapy		

Skin

☐ Hives	☐ Itching	☐ Itching
☐ Change in moles	☐ Rash	☐ Sores that won't heal

Neuropsychiatry

☐ Stroke	☐ Seizures	☐ Fainting
☐ Dizziness	☐ Headaches	☐ Depression
☐ Anxiety	☐ Psychiatric care	☐ Forgetfulness
☐ Nervousness	☐ Numbness	

MEN only

☐ Breast lump	☐ Erection difficulties	☐ Lump in testicles
☐ Penis discharge	☐ Sore on penis	☐ Other _____

WOMEN only

☐ Abnormal Pap smear	☐ Bleeding between periods	☐ Breast lump
☐ Extreme menstrual pain	☐ Hot flashes	☐ Nipple discharge
☐ Painful intercourse	☐ Vaginal discharge	☐ Other _____

Date of last menstrual period _____Number of pregnancies ____Number of children _____Did you breast feed?

Could you be pregnant? _____Date of last mammogram _____Date of last menstrual period _____

MEDICAL DOCTORS ARE LICENSED AND REGULATED BY
THE MEDICAL BOARD OF CALIFORNIA
1-800-633-2322
www.mbv.ca.gov

PATIENT/GUARDIAN
SIGNATURE_____DATE_____

Please indicate any of the following cosmetic procedures/services you would be interested in:

___Botox Cosmetic Injectable ___Facelift-Necklift ___ Juvederm/Restalyn Products ___ Brow Lift ___ Lip Augmentation Implants/Injectables_____ ___Eyelids ___Laser Resurfacing/Skin Rejuvination ___Rhinoplasty (Nose)

___Other Cosmetic Interests :_____ _____

_____ _____

******COSMETIC PROCEDURES/PRODUCTS ARE NOT COVERED BY ANY INSURANCE PLANS***

MICHAEL J. SUNDINE M.D., F.A.C.S.

Certified by The American Board of Plastic Surgery

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RECORDS RELEASE

I herby authorize and request as needed you release records to the following persons(s) or physicians(s):

NAME RELATIONSHIP

NAME RELATIONSHIP

NAME RELATIONSHIP

The complete medical records in your possession, concerning my medical history and or treatment.

Including:

All physicians notes, lab work, lab results, xrays, operative reports, patient history forms, photos, pathology reports, diagnostic studies, prescription history.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing this form you acknowledge you ere advised of the Notice of Privacy Practices for Michael J. Sundine, M.D., Inc. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. The Notice of Privacy is available on our website at www.drsundine.com and in our office. You may request a copy of the Notice of Privacy.

Signature of Patient/Patient Representative Date

Name of Patinet/Patient Representative (please print) Relationship to Patient

Patient Signature Date

Open Payments Database Notice:

"The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov."

Patient/Patient Representative Signature Date