

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 Rejuvenation-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 AN ID CARD FOR INSURANCE, PLEASE HAND IT TO THE RECEPTIONIST 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 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 CONTROL 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 PROVIDED 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?

- | | | |
|---|---|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Deep Venous Thrombosis | <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> 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?

- | | | |
|--|--|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> 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

- | | | |
|--------------------------------------|---------------------------------|--|
| <input type="checkbox"/> Chills | <input type="checkbox"/> Fevers | <input type="checkbox"/> Loss of sleep |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Sweats | |

Eye, Ear, Nose, and Throat

- | | | |
|--|---|--|
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Crossed eyes |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Double vision | <input type="checkbox"/> Earache |
| <input type="checkbox"/> Ear discharge | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Vision-flashes, halos |

Cardiovascular

- | | | |
|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Angina/chest pain |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Heart failure |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Varicose veins |

Respiratory

- | | | |
|---|--|--|
| <input type="checkbox"/> Abnormal chest x-ray | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Recent chest infection | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Shortness of breath at night | <input type="checkbox"/> Shortness of breath on exertion | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Cough with sputum | <input type="checkbox"/> History of tuberculosis |

Gastrointestinal

- | | | |
|---|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Bloating | <input type="checkbox"/> Bowel changes |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Excessive hunger |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Gas | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Vomiting blood | |

Genitourinary

- | | | |
|--|--|---|
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Lack of bladder control |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> History of kidney disease | <input type="checkbox"/> History of urinary disease |

Musculoskeletal

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Herniated disc |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Neck problems | <input type="checkbox"/> Back problems |
| <input type="checkbox"/> Leg problems | <input type="checkbox"/> Arm problems | |

Endocrine

- | | | |
|-----------------------------------|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Taken steroids |
|-----------------------------------|--|---|

PATIENT/GUARDIAN INITIALS _____

Hematologic/Oncologic/Infectious

- | | | |
|--|--|---|
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Blood clots in legs | <input type="checkbox"/> Blood clots in lungs |
| <input type="checkbox"/> Radiation therapy | | |

Skin

- | | | |
|--|----------------------------------|--|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Itching | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Change in moles | <input type="checkbox"/> Rash | <input type="checkbox"/> Sores that won't heal |

Neuropsychiatry

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness | |

MEN only

- | | | |
|--|--|--|
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Erection difficulties | <input type="checkbox"/> Lump in testicles |
| <input type="checkbox"/> Penis discharge | <input type="checkbox"/> Sore on penis | <input type="checkbox"/> Other _____ |

WOMEN only

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal Pap smear | <input type="checkbox"/> Bleeding between periods | <input type="checkbox"/> Breast lump |
| <input type="checkbox"/> Extreme menstrual pain | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> 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 Rejuvenation ___ 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

1525 Superior Ave-Suite 208-Newport Beach-Ca-92663

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 are 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.dr Sundine.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

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

200 Newport Center Drive-Suite301-Newport Beach-Ca-92660-949-706-3100

Out of Town Patient Memorandum

Dr. Sundine and his staff appreciate that you have travelled from out of town to seek potential surgical services provided by Dr. Sundine practice. We would like to take this opportunity to clarify the unique situation(s) that may arise from treating patients from out of town, that may not initially be obvious.

As you may or may not be aware plastic surgery involves procedures that carry substantial risks of complications that may require additional medical care. Complications such as infection, bleeding, scarring and other concerns often occur after you have returned home, it is not possible to practice adequate patient care from a distance and you may require further care in your hometown.

Should a complication or difficulty arise post-operatively, you will need to immediately seek your own medical care in your local area. Dr. Sundine's practice will not be able to provide medical services from a distance or over the phone. Please understand that any expenses incurred due to further treatment needs/post-surgical care are patient responsibility.

Your signature below memorializes and provides documentation that you have read and understand this concern for our out of town patients.

Patient Signature_____ Date _____

Witness Signature_____ Date _____

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

Warning Regarding HIPPA and Email/Text Communications

Dr. Sundine and his practice take every step possible to maintain your privacy and to stay compliant with all HIPAA laws. However, in current technology it is not possible to ensure that complete privacy between you and our practice for email and text communications. In other words, if you are to text or email any of your medical information or photos to our practice it cannot be guaranteed that all the information is compliant with HIPAA privacy laws, and it is possible that some of it could be inadvertently exposed. For this reason, we want to make clear that HIPPA compliance is not possible for all text and emails between you and either Dr. Sundine or any of his staff and you should be warned of the possibility of sensitive information being unprotected.

You signature below demonstrates, and confirms, that you have read the above information, and that you are clear on this important issue, and you have a complete understanding of the above information.

PATIENT SIGNATURE

Date

Witness Signature

Date

WELCOME TO
MICHAEL J SUNDINE M.D.,F.A.C.S. -BOARD CERTIFIED PLASTIC SURGEON
200 NEWPORT CENTER DRIVE SUITE 301 NEWPORT BEACH CA 92660
Phone-949-706-3100

Welcome! Thank you for choosing the Michael J Sundine MD Inc . *Your Plastic Surgery health care needs are an important priority.* Our goal to be available and responsive to your needs. The following information is provided to introduce you to our practice and to help you plan your office visits. Please feel free to call for any questions or for additional information.

- Office administrative phone lines and hours are 9 am to 5 pm Monday through Friday, with routine consultation/office visits scheduled, as available from 09:30am-4:00 pm.
- Please call 949-706-3100 during regular office hours to schedule an appointment.
- If you leave a voicemail, please provide a number where it is best to reach you.
- If you are unable to keep an appointment, please call the office in advance. After hours, you may leave a message with our exchange service or on the answering voice mail.
- If you need to contact the physician after hours, your call will be answered by our exchange service, or voicemail availability. If it is medical emergency, please call 911.
- Parking, including handicap parking, is available in the parking lot in front of the office.
- You will be asked to provide a photo ID at your first visit. This is part of our privacy/identify theft program.
- Our office maintains strict compliance with federal HIPAA privacy requirements. If you would like any health information released to another person, you must sign a HIPAA release identifying the individual to whom you want information released.
- We accept cash, Zelle, credit cards, and debit cards.
- FOR INSURANCE CASES: Co-pays and deductibles are due in full at the time of the appointment if your insurance is a contracted insurance group that Dr. Sundine is accepting or contracted with. Dr. Sundine is not contracted with any PPO insurances. There are two HMOs: Those are: Optum-Monarch HMO, Hoag Physician Partners HMO. Otherwise, any and all fees are due and in full at the time of the visit. Please see the additional financial policy included in your new patient paperwork for further information on non-contracted payment requirements.
- COSMETIC-CASH-NON CONTRACTED fees are due in full at the time of services. Surgery fees are due in full 14 days prior to surgery date. Initial specialist consultation fee is \$325, and is due at the time of the visit. See above for payment option methods.
- Please note that email and text communication are limited, due to HIPPA rules. We will ask that you sign a disclosure regarding HIPAA and Text/Email memorandum, which will be included in new patient packet. Please note the main office phone number: **949-706-3100**. **Always be sure to leave a message** ,including your name, date of birth, brief message regarding your call and a number where you can be reached, as well as an alternative number. Please know that all calls are retrieved and will be responded to.
- Please visit our website, www.drsundine.com, where you can review procedure specific information, as well as pre and post operative care instructions, as well as other information
- There is a \$25 dollar record reproduction fee, and mailing fee, for each request of medical records. This fee is due prior to any record reproduction.
- Dr. Sundine is a specialist, and as such, from time to time, emergencies come up and there might be a need to reschedule your appointment. We do appreciate your understanding of this, and will work with you to coordinate reschedules as needed.

Thank you for choosing Michael J Sundine MD Inc. We look forward to providing you with the highest quality of services to support your plastic surgery health care needs. Wishing you the best of health!

Sincerely yours,
MICHAEL J SUNDINE MD Inc