



*Solano Plastic Surgery*  
INC

TRUSTED EXPERTISE.  
PERSONAL CARE.  
EXCEPTIONAL RESULTS.

## Patient Registration Form

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ M \_\_ F  
Last Name First Name Middle Initial Today's Date

\_\_\_\_\_  
Home Address: Street City State Zip Code

(\_\_\_\_) (\_\_\_\_) (\_\_\_\_)  
Home Phone Number Work Phone Number Cell Phone Number

\_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_  
Date of Birth Age Email (Please Print Clearly)

\_\_\_\_\_  
Occupation/Employer Address City State Zip Code

\_\_\_\_\_  
Emergency contact person Relationship Telephone Number

Purpose of Consultation \_\_\_\_\_ Any previous plastic surgery consults? \_\_\_\_\_

Any previous plastic surgery? \_\_\_\_\_ Were you satisfied? \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_ Friend \_\_\_\_\_ Family \_\_\_\_\_ Patient \_\_\_\_\_ Doctor \_\_\_\_\_ Website \_\_\_\_\_ Other

Name of person who referred you (Optional) \_\_\_\_\_

\_\_\_\_\_  
Name of Spouse

\_\_\_\_\_  
Home Address: Street City State Zip Code

(\_\_\_\_) (\_\_\_\_)  
Work Phone Number Cell Phone Number

\_\_\_\_\_  
Occupation/Employer

\_\_\_\_\_  
Primary Care Physician Phone

\_\_\_\_\_  
Primary Insurance Medical Group Name

\_\_\_\_\_  
Policy/ID # Group #

Patient Medical History

Height \_\_\_\_\_ Weight \_\_\_\_\_

Are you being treated by your Primary Care Physician and/or other Specialist for medical conditions? YES NO

If yes, please explain: \_\_\_\_\_

Do you wear contacts? YES NO

Are you legally blind? YES NO

Right Eye  Left Eye  Both Eyes

Are you allergic to any medications? YES NO

If yes, please explain: \_\_\_\_\_

Are you currently taking any medications? YES NO

If yes, please explain: \_\_\_\_\_

Are you allergic to latex? YES NO

If yes, have you been tested? YES NO

Are you currently taking any medications containing aspirin? YES NO

If yes, please circle which ones from the following list:

Aspirin Bayer Excedrin Bufferin Ibuprofen Advil Nuprin Motrin Other \_\_\_\_\_

Are you currently taking any medications for arthritis? YES NO

If yes, please list \_\_\_\_\_

Prior Surgeries? YES NO

If yes, please list \_\_\_\_\_

Any complications with surgery? YES NO

If yes, please explain \_\_\_\_\_

Any complications with anesthesia? YES NO

If yes, please explain \_\_\_\_\_

Any significant illness as a child? YES NO

Any significant illness as an adult? YES NO

If yes, please explain \_\_\_\_\_

Any significant illness in your family? YES NO

If yes, please explain\_\_\_\_\_

Do you smoke? YES NO

If yes, how many per week? \_\_\_\_\_ total # of cigarettes/\_\_\_\_\_ total # of packages

Do you drink alcohol? YES NO If yes, how many glasses per week?\_\_\_\_\_

**Have you or anyone in your family ever had a blood clot?** YES NO

**Have you or anyone in your family ever been on blood thinners?** YES NO

**Have your or anyone in your family ever been diagnosed with a blood clotting disorder?** YES NO

**Has anyone in your family had a disease called "purpura fulminanas?"** YES NO

**Have you ever been diagnosed with lupus or any other autoimmune disease?** YES NO

---

PLEASE PLACE A (√) NEXT TO ALL THAT APPLY

**Airway**

Capped, chipped, broken teeth

Unable to open your mouth fully

**Respiratory**

Breathing Problems

Used tobacco within the year

Sleep Apnea

Persistent Cough

Use breathing devices

Sputum, Phlehm, mucus production

Asthma, wheezing

Bronchitis, Emphysema, COPD

Tuberculosis

Shortness of breath after walking two flights of stairs

Recent cold

**Heart**

Heart problems/irregularities

Chest pain, angina, MI, heart attack

Leg swelling, edema, CHF

Paralysis

High blood pressure

Heart murmur, prolapsed mitral valve, rheumatic fever

Legs cramp while walking

**Skin**

Problems with wounds healing

Scar badly

Bruise easily, excessive bleeding

Allergic reaction to adhesive tape

**Endocrine**

Diabetes, high or low blood sugar

Thyroid problems, heat or cold intolerance

**Abdomen**

Hiatal hernia, frequent regurgitation, heartburn

Ulcers, vomiting blood

Kidney disease

Hepatitis, jaundice

Liver disease, cirrhosis

**Genitourinary**

Difficulty passing urine

At risk for AIDS or venereal disease

Possible you are pregnant

**Musculoskeletal**

Physical limitations, appliances, prostheses

Arthritis (jaw, neck, back)

Phlebitis

**Neurological/Psychiatric**

Seizures, convulsions, fainting, epilepsy

Stroke, fleeting blindness, weakness

Psychiatric treatment

Anxious about possible surgery

**General**

Headaches

Unexplained weight loss

Glaucoma

Steroid use within one year

Blood transfusions

Chemotherapy

Used recreation drugs within the last year

Anemia

**If you placed a (√) mark in any above the above, please explain:**

---

## **AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS**

This is a consent document that has been prepared to help inform you concerning permission to take photographs and to use these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by Dr. Brian Klink.

Medical photographs may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photographs for a stated purpose.

### **1. CONSENT TO TAKE PHOTOGRAPHS**

I, \_\_\_\_\_, hereby authorize Brian Klink, M.D. and/or his associates or licensees to take pre-operative, intra-operative and post-operative photographs.

### **2. CONSENT FOR RELEASE OF PHOTOGRAPHS**

I, \_\_\_\_\_, hereby authorize Brian Klink, M.D. and/or his associates or licensees to use pre-operative, intra-operative and post-operative photographs for professional medical purposes deemed appropriate including them in any print advertising, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

**ACKNOWLEDGMENT OF PATIENT PRIVACY PRACTICE NOTICE**

I have been informed of Solano Plastic Surgery's Patient Privacy Practices. I am aware that this notice describes how protected health information (PHI) about me may be used and disclosed and how I can get access to this information. I have the right to review the Notice of Privacy Practices prior to signing this consent. Solano Plastic Surgery reserves the right to revise its Notice of Privacy Practices at anytime. I have the right to a paper copy of this notice by asking a staff member at the front desk or writing to: Solano Plastic Surgery, 1001 Nut Tree Road, Suite 130, Vacaville, CA 95687.

I am also aware that my Medical Record may be used in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

By signing this form, I am consenting to Solano Plastic Surgery use and disclosure of my PHI.

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, Solano Plastic Surgery may decline to provide treatment on me.

---

Patient Name (Please print)

---

Signature of Patient

---

Date

**PROTECTED HEALTH INFORMATION RELEASE**

Solano Plastic Surgery’s policy is to maintain the confidentiality of your medical record, also referred to as Protected Health Information (PHI). Our office will not disclose personal or medical information about you unless authorized by you or mandated by law.

As a patient, you have the right to determine who may receive medical information about you from our office. Some patients elect no one other than themselves to receive information while others elect specific family members or friends who may receive their information. In order to assure your PHI continues to be secure, please take a moment to complete the bottom portion of this form.

Please list the first and last name of any individual allowed to receive your PHI. If no one other than you is allowed, please put a check mark in the box next to “self only”.

Self Only

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
Patient Name (Please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient

If at any time you wish to make a change, please ask us for another form. Thank you!