PATIENT REGISTRATION INFORMATION

Choose Title

Marital Status *

Age *

Name *

First Name Middle Name Last Name

Home Number *

Area Code Phone Number

Insured Date of Birth *

Month Day Year

Cell Number *

Area Code Phone Number

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Email *

example@example.com

Should it be necessary to communicate with you regarding matters related to your care at our office (i.e. medical information, appointment reminders, account information, demographic updates, etc.), we request permission to contact you by e-mail in addition to the standard methods of telephone or first class mail. Do you give Dr.Park and her staff permission to contact you by electronic mail for such purposes? *

YES

NO

Will you be responsible for your account? *

YES

NO

If no, Name of person responsible.

Your occupation

Employer's Name

Employer's Number

Area Code Phone Number

PATIENT'S REFERRAL INFORMATION

How did you hear about Dr. Park?

If referred by a friend, may we thank him or her?

YES

NO

PATIENT'S INSURANCE INFORMATION

Name of Insured *

Your relationship to insured: *

PRIMARY insurance company's name *

Insurance ID# *

Insurance Phone Number

Area Code Phone Number

Insured Date of Birth

Month Day Year

Insurance Billing Address

Street Address

City State

Any SECONDARY insurance?

EMERGENCY CONTANCT INFORMATION

Name *

First Name Last Name

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Relationship: *

Cell Phone Number *

Area Code Phone Number

Home Phone Number *

Area Code Phone Number

I agree that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original. *

Date

Month Day

Year

Signature

Date

Medical History & Questionnaire

Patient Name

First Name Last Name

Patient Gender

Patient Height (Feet)

Patient Weight (lbs)

Date of Birth

Month Day

Year

Current & Past Medical History

Do you have any of the following? (Please check all that apply)

- ☐ High Blood Pressure
- ☐ Heart Trouble - murmur, palpitation (arrhythmia), pacemaker
- ☐ Chest Pain (angina) heart attack, heart failure
- ☐ Scarlet Fever, rheumatic fever
- ☐ Asthma, T.B., lung problems, shortness of breath while walking
- ☐ Emphysema
- ☐ Blood Disorder, anemia, clotting problems, phlebitis
- ☐ Seizure, epilepsy, convulsions
- ☐ Fainting spells, blackouts, stroke
- ☐ Frequent or severe headaches
- ☐ Diabetes
- ☐ Thyroid condition, goiter
- ☐ Cancer
- ☐ Jaundice, hepatitis, liver problems
- ☐ Kidney, bladder problems
- ☐ Poor Wound healing, radiation treatment
- ☐ Abnormal response to cold, Raynaud's disease
- ☐ Rheumatoid arthritis, scleroderma, collagen disease, lupus
- ☐ Skin pigment problems, keloid, poor scarring
- ☐ Fever blisters, cold sores, herpes simplex

- [ ] Frequent infection or boils
- [ ] Blood Transfusion
- [ ] Significant emotional problems
- [ ] Psychiatric care
- [ ] Recent fever or cold
- [ ] Venereal Disease
- [ ] Neurological Disorders

Please list any Operations you have had and dates of each

Recent Examinations

- [ ] History & Physical
- [ ] EKG(electrocardiogram)
- [ ] Chest X-ray
- [ ] Lab Work

Please list any drug allergies (Including latex, tape, dyes, etc.)

If no known allergies, write "No Known Drug Allergies"

Please list the dates of recent examinations here

Please list your Current Medications

Are you taking or have taken any of the following in the last 6 months?

- ☐ Aspirin or aspirin containing products
- ☐ Insulin
- ☐ Anticoagulants, blood thinners
- ☐ Tranquilizers or sedatives
- ☐ Steroids, cortisone or ACTH
- ☐ Any over-the-counter drugs or herbal supplements, including aspirin, motrin, alleve, advil, ibuprofen, nuprin, ginko biloba, vitamin E

Social History

Alcohol Comsumption

Caffeine Consumption

Do you smoke?

If answered "No but I have in the past"

Please write when you quit & # of packs used to smoke

Has any relative ever had (choose all that apply)

- ☐ Cancer, breast cancer
- ☐ Lung disease, asthma
- ☐ Reaction to anesthesia
- ☐ Rheumatoid arthritis, scleroderma, lupus
- ☐ Kidney disease
- ☐ Epilepsy
- ☐ Blood disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Mental disease

Any other information you would like the doctor to know?

SUNNY PARK
FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Consent to Obtain and Publish Photographs

Name

First Name Last Name

Date of Birth

Month Day Year

I consent photographs may be taken of me or part of my body under the following conditions:

1. **Photographs may be taken before, during and after my surgery or treatment to document my progress as part of my medical record.**
2. **The photographs may be taken only with the consent of my physician, Sunny Park MD, and under such condition and at such times as may be approved by her.**
3. **The photographs may be taken by Sunny Park MD or by a photographer approved by her.**
4. **The photographs shall be used for medical record. In addition, these photographs may be used for the purpose of diagnosis, education, research or for publication, either separately or in connection with each other in Dr. Sunny Park's professional website, Social media sites, professional journals or medical books. In any such publication, I shall not be identified by name. I hereby release Sunny Park MD Inc and its officers, employees and agents from any and all claims arising in any way out of the use described above of such photographs. I further waive the right to inspect and approve such photographs prior to their use.**

Signature

Date

Month Day Year

Informed Consent For Telemedicine Services with Sunny Park M.D.

901 Dover Drive Suite 126 Newport Beach, CA 92660

Name

First Name Last Name

Date of Birth

Month Day Year

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Introduction:

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient Medical Records
- Medical Images
- Live two-way audio/visual

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits

- Improved access to medical care by enabling a patient to remain in a remote area while the physician obtains test results and consults form healthcare practitioners at a distance/other sites.
- More efficient medical evolution and management
- Obtaining expertise of a distant spcialist

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (I.e. poor image quality) to allow for appropriate medical decision making by Dr. Sunny Park and consultants;
- Delays in medical evaluation and treatment could occur due to equipment failures or deficiencies
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information:
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions of allergic reaction or other judgement error;

By signing this form, I attest to and understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Dr. Sunny Park has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform Dr. Sunny Park of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Dr. Sunny Park to use telemedicine in the course of my diagnosis and treatment.

Date

Month Day Year

Signature

Sunny Park MD – Privacy Officer

901 Dover Drive #126 Newport Beach, CA 92660 (949)-873-5089

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

YES
NO

Email

example@example.com

Signature

Date

Month Day Year

Name

First Name Last Name

Phone Number

Area Code Phone Number

If not signed by the patient, please indicate relationship:

- ☐ Parent or Guardian of minor patient
- ☐ Guardian or conservator of incompetent patient

Name & Address of Patient