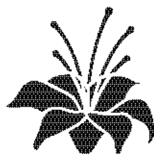


Lily Lee, MD

Plastic & Reconstructive Surgery

Tel: 626-817-0818 Fax: 626-817-0844
www.LilyLeemd.com

100 E. California Blvd.
Pasadena, CA 91105

73-180 El Paseo
Palm Desert, CA 92260

Date: ________________________

Name: ____ Age: ____________ DOB: _______/______/______

Address: ______________________________________ Cell: (_______)______________________________________

City ________________________________Zip________ Alt. Tel: (_______)______________________________________

Email: ____ FB.__________ Instagram: __________ Tik Tok:______________

Referring Physician: _____________________________________

Preferred Pharmacy / Address:_____________________________ Pharmacy Phone Number:____________________________

How did you hear about Dr. Lee? ____

Have you been to our website (www.lilyleemd.com)?______________ Was our website helpful? □No □Yes If No, pls. list reason:

____

What is the reason for your visit today? (Circle all applicable procedures below)

Nose & Face	Breast & Body	MediSpa
Brow Lift	Breast Augmentation	Botox®
Droopy Eyelids	Breast Lift	Fillers
Eye Bags / Puffiness	Breast Reduction	Ultherapy
Face Lift	Breast Implant Revision	Thinning Hair / Eyelashes
Neck Lift	Mommy Makeover	Pore Tightening
Lash Growth (Latisse)	Abdominoplasty (Tummy Tuck)	Scar Treatment
Chin Augmentation	CoolSculpting	Wrinkle Anti-Aging Treatments
Ear Tuck	Brachioplasty (Arm Tuck)	Microneedling
	Liposuction	Photo Facial
	Fat Grafting	Morpheus8
Other___________________	Other______________________________	Kybella
Other___________________	Other______________________________	PDO Thread Lift
Other___________________	Other______________________________	Other___________________

Please describe why you are interested in having the procedure(s) listed above:____

____

Have you consulted with other physicians about procedure(s) indicated above: □No □Yes

Is this procedure a revision from a previous surgery □No □Yes If yes, how many previous surgeries?____________________

What is your "ideal time frame" for procedure(s) completion ____

Do you have reliable transportation? _________ Who will be transporting you to and from the surgery center? _______________

Age ________ Weight __________ Height ______________ B/P _____________ (taken in office)

Employer ______________________ Address ____

Occupation: ____ Marital Status: ________________________________

Primary Insurance Co. ___________________________________ Policy # _____________________________________

Group # ______________ Name of person insured _________________________________ SS# ___________________

Eligibility Phone # ____ Copay _____________________________________

Secondary Insurance Co. ___________________________________ Policy # ___________________________________

Group # ______________ Name of person insured _________________________________ SS# ___________________

Eligibility Phone # ____ Copay _____________________________________

HEALTH INFORMATION

Personal Past History:
Do you have any chronic medical problems? (Circle all that apply)

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
Autoimmune Disease	Asthma	Other _________________

Is there a personal or family history of anesthetic complications? □No □Yes
If yes, please explain____

Do you have a history of falls? □No □Yes
If yes, have you discussed with your primary care doctor? □No □Yes

Have you had your flu vaccine this year? □No □Yes

Family History:
Do you have a family history of any medical problems? (Circle all that apply) Please indicate family members.

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
Autoimmune Disease	Asthma	Other _________________

Please list all prior operations:	Date	List any complications
1.________________________	__________	________________
2.________________________	__________	________________
3.________________________	__________	________________
4.________________________	__________	________________
5.________________________	__________	________________

Please list all prior Hospitalizations:	Date	List any complications
1.________________________	__________	________________
2.________________________	__________	________________
3.________________________	__________	________________
4.________________________	__________	________________
5.________________________	__________	________________

Please list **ALL** medications and/or dietary supplements including:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

1. ________________________ 6. ________________________
2. ________________________ 7. ________________________
3. ________________________ 8. ________________________
4. ________________________ 9. ________________________
5. ________________________ 10. ________________________

Please list **ALL** allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc).

1. ________________________ 4. ________________________
2. ________________________ 5. ________________________
3. ________________________ 6. ________________________

Are you ☐ Vegan ☐ Lacto-Ovo Vegetarian ☐ Pescatarian ☐ Other (please specify) ____________________
Please list any other dietary restrictions: ____

Social History:

Have you ever used tobacco products? □No □Yes If yes, how long?__________ How much?__________

Which tobacco product(s) have you used?____________________________

If you are a former smoker, state the year you stopped: __________________

Past or current use of Nicotine Gum, Patch, or any other type of stop-smoking aid: □No □Yes

If yes, please list: ____

Alcohol Consumption: _________Never (Do not consume alcohol) ________ Rare (1-2 drinks a week)

_________ Moderate (7-10 drinks a week) _______ Heavy (daily or more than 10 drinks a wk)

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

Are you feeling hopeless about the present/future? □No □Yes

Do you currently have thoughts of harming yourself? □No □Yes

Review of Systems:

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure Y ___ N ____

Heart Attack Y ___ N ____

Angina/chest pain Y ___ N ____

Heart bypass surgery Y ___ N ____

Pacemaker Y ___ N ____

Heart Failure Y ___ N ____

Irregular Heartbeat Y ___ N ____

Heart Murmur Y ___ N ____

Do you exercise? Y ___ N ____

Comments: __________________________

NEUROLOGICAL

Stroke Y ___ N ____

Seizures Y ___ N ____

Fainting Y ___ N ____

Dizziness Y ___ N ____

Headache Y ___ N ____

Double Vision Y ___ N ____

PSYCHIATRIC

Depression Y ___ N ____

Anxiety Y ___ N ____

Psychiatric Care Y ___ N ____

Obsessive Compulsive Disorder Y ___ N ____

ENDOCRINE

Diabetes Y ___ N ____

Thyroid Disease Y ___ N ____

Taken Steroids Y ___ N ____

HEMATOLOGIC/ONCOLOGIC/

Bleeding Tendency Y ___ N ____

Easy Bruising Y ___ N ____

Anemia Y ___ N ____

Sickle Cell Disease Y ___ N ____

Blood clots in legs Y ___ N ____

Blood clots in lungs Y ___ N ____

Radiation Therapy Y ___ N ____

URINARY/REPRODUCTIVE

Kidney Disease Y ___ N ____

RESPIRATORY

Abnormal Chest X-ray Y ___ N ____

Asthma Y ___ N ____

Bronchitis Y ___ N ____

Emphysema Y ___ N ____

Recent Chest Infection Y ___ N ____

Shortness of Breath Y ___ N ____

Shortness of Breath at night Y ___ N ____

Shortness of Breath on exertion Y ___ N ____

Cough Y ___ N ____

Cough with Sputum Y ___ N ____

Sleep Apnea Y ___ N ____

-Use a C-PAP Machine Y ___ N ____

MUSCULOSKELETAL

Sciatica Y ___ N ____

Herniated disc Y ___ N ____

Arthritis Y ___ N ____

Rheumatoid Y ___ N ____

Neck, Back, Arm,Leg Prob Y ___ N ____

INFECTIOUS

GASTROINTESTINAL

Jaundice Y ___ N ____

Hepatitis Y ___ N ____

Ulcers Y ___ N ____

Hiatal Hernia Y ___ N ____

Heartburn Y ___ N ____

SKIN

Basal cell skin cancer Y ___ N ____

Melanoma Y ___ N ____

Urinary Disease Y ___ N ____
Dialysis Y ___ N ____
If Female, could you be preg? Y ___ N ____
Number of live births______________________
Number of pregnancies ___________________
Date of last mammogram __________________
Date of date of menses (period)_____________

Staph Infection Y ___ N ____

EYES

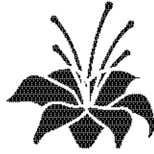
Cataracts Y ___ N ____
Glaucoma Y ___ N ____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ________________________________ and assign directly to Lily Lee, M.D., Professional Corporation, all Medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability is such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_______________________________________ _____________________
Signature of Insured/Guardian Date

_______________________________________ _____________________
Patient's Signature Date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PHOTOGRAPHIC RELEASE

I HEREBY GIVE PERMISSION to Dr. Lily Lee and/or her Associate(s) or any assistant they may designate, to take photographs of me or my body parts in connection with the plastic surgery procedure(s) to be performed by Dr. Lily Lee and/or for diagnostic purposes. I agree that these photographs will remain their property and a part of my permanent medical record.

I PROVIDE THIS AUTHORIZATION as a voluntary contribution in the interests of patient education. I understand that such photographs shall become the property of Dr. Lily Lee and may be retained by Dr. Lily Lee or released by Dr. Lily Lee for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to publication in medical journals and textbooks, physician photo books, physician website or for the purpose of informing the medical profession, the general public, or a patient about plastic surgery procedures and methods.

I FURTHER AUTHORIZE them to use such photographs for teaching purposes. It is specifically understood that I shall not be identified by name. I understand that in some circumstances the photographs may portray features that will make my identity recognizable, even in instances where every effort is made to conceal my identity.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**").

I release and discharge Dr. Lily Lee and all parties acting under her license and authority from all rights that I may have to the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

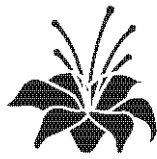
I certify that I have read the above authorization and release, and fully understand the terms.

Patient Printed Name___________________________________

Patient Signature_______________________________________

Witness Signature______________________________________

Date___________________________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Notice of Privacy Practices

To our patients –

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations
created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy –

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances –

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement officer.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To a federal official for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement officials.
8. For Workers Compensation and similar programs.

Your rights regarding your health information –

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychological notes. You must submit your request in writing to the Surgery Center.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to The Surgery Center. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Lily Lee M.D. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for use and disclosures that are not identified by this notice or permitted by applicable law.

Notice of Privacy Practices

I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practices by Lily Lee, MD

____

Name of Patient (Please Print)

____

Signature of Patient

____

Date