David Benvenuti, M.D.

Plastic and Reconstructive Surgery

DATE_____

REFERRED BY_____

Personal Information

PATIENT'S NAME_____DOB_____AGE_____SEX F M

ADDRESS_____CITY/STATE_____ZIP_____

HOME PHONE_____CELL_____E-MAIL_____

LAST 4 OF SOCIAL SECURITY #_____ DRIVER'S LICENSE #_____

EMPLOYED BY_____OCCUPATION_____

BUS PHONE_____ MARITAL STATUS S M D W

HOBBIES & INTERESTS_____

SPOUSE'S/GUARDIAN NAME_____CELL_____

EMPLOYED BY _____ OCCUPATION_____

EMERGENCY CONTACT_____PHONE_____

Medical History

PHYSICIAN(S)_____

ALLERGIES TO MEDICINE_____

	YES	NO		YES	NO		YES	NO
DIABETES	❑	❑	**NERVOUS DISORDERS**	❑	❑	**HEPATITIS**	❑	❑
ANEMIA	❑	❑	**RHEUMATIC FEVER**	❑	❑	**GLAUCOMA**	❑	❑
PROLONGED BLEEDING	❑	❑	**KIDNEY PROBLEMS**	❑	❑	**HIV/AIDS**	❑	❑
PNEUMONIA	❑	❑	**LIVER PROBLEMS**	❑	❑	**BLOOD CLOTS**	❑	❑
EPILEPSY	❑	❑	**BONE DISORDERS**	❑	❑	**HAVE YOU EVER SMOKED**	❑	❑
FAINTING/DIZZINESS	❑	❑	**TUBERCULOSIS**	❑	❑	**WHEN WAS YOUR LAST**		
HEART TROUBLE	❑	❑	**HIGH BLOOD PRESSURE**	❑	❑	**CIGARETTE**_____		
ASTHMA	❑	❑	**ENDOCRINE PROBLEMS**	❑	❑	***OTHER***_____		

Insurance Information

INSURED'S NAME_____INSURANCE ID#_____

INSURANCE CO./GROUP_____PHONE _____

*Dr. Benvenuti is not a provider for any insurance companies.

Method of payment for surgery: ❑ Cash / Check ❑ Credit Card ❑ Financing

PATIENT'S SIGNATURE_____DATE_____

(OR LEGAL GUARDIAN IF PATIENT IS UNDER 18 YEARS)

NOTICE OF PRIVACY PRACTICES:

Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

By signing this form you acknowledge receipt of the ***Notice of Privacy Practices*** of

DAVID BENVENUTI, M.D.

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.
Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at (949) 650-2345.

I acknowledge receipt of the ***Notice of Privacy Practices*** *of*
DAVID BENVENUTI, M.D., F.A.C.S.

Signature :_____ **Date:**_____
(parent/patient/conservator/guardian)

Print Name: _____

FOR OFFICE USE ONLY

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

_____

Patient Consent for Use and Disclosure of Protected Health Information

With your consent, David Benvenuti, M.D., may use and disclose protected health information about you to carry out Treatment, Payment and Health Care Operations. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We have the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 355 Placentia Ave., Suites 99 & 104, Newport Beach, CA 92663.

With your consent, David Benvenuti, M.D., may call your home or office and leave a message in reference to any items that assist the practice in carrying out Treatment, Payment, and Health Care Operations such as appointment reminders, insurance items and any call pertaining to your clinical care.

With your consent, David Benvenuti, M.D., may mail to your home or office any items that assist the practice in carrying out Treatment, Payment and Health Care Operations, such as appointment reminder cards and patient statements.

I give my consent to electronically send or fax my records for the purpose of Treatment, Payment, or Health Care Operations and understand that I may withdraw this consent at any time in writing. I understand that my medical records may be transmitted electronically or by fax and may be received in error by a third party. In the event that this should occur, I absolve, David Benvenuti, M.D.,of all liability.

You have the right to request that we restrict how we use or disclose your protected health information to carry out Treatment, Payment, and Health Care Operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your protected health information to carry out Treatment, Payment and Health Care Operations. This consent may be revoked in writing except to the extent that we have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may decline to provide treatment for you.

Signature of Patient or Legal Guardian_____Date_____
This Authorization Will Remain Standing Until Revoked in Writing

***Patient's Name*_____*Date of Birth*_____**

Print Name of Patient or Legal Guardian_____Date_____

ONLY SIGN BELOW IF YOU ARE DECLINING THIS CONSENT

I,_____, decline to the use and disclosure of my protected health information to carry out treatment, payment, and health care operations.