Melanie Ho Erb, M.D.
A Surgeon's Hands, A Woman's Touch
Laser Cosmetic and Oculo-Facial Plastic Surgery

Demographics NEW PATIENT

Today's date

Name:
Last
First
Preferred First Name

Address:
Street
City
State
Zip Code

Email addresses:
1. Email address used most often
2. Do you have a Gmail address? YES NO
3. Gmail address, if you have one
4. How often do you use Gmail? DAILY MONTHLY YEARLY NEVER

Phone numbers (we will generally use your cell phone):
Home
Cell
Work

Birth Date
Age
Sex

How did you hear about us?
Referred by doctor:
- Doctor's Name
- Doctor's Address
- Doctor's Phone number
- Would you like us to send a letter that you were seen by us to your referring doctor? YES NO

Referred by friend/family:
- Friend's Name
- Friend's address or email address
- Would you like us to send a thank-you note or email to your friend/family? YES NO

Internet:
- Search words
- Websites viewed

Note:
Does your cell phone receive text messages? YES NO

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Emergency Contact

Today's date:_____
Name:_____

Name of Emergency Contact:
Relationship to patient:
Phone (may list multiple):
- cell
- work
- home

Email:
Address:

In the event of an emergency, I understand that Melanie Ho Erb, M.D. and staff may disclose information to my emergency contact listed above that may be protected by the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I authorize Melanie Ho Erb, M.D. and staff to release protected health information to my emergency contact listed above, if deemed necessary for the emergency. This authorization is in effect until I choose a different name of emergency contact.

Print Name_____
Signature_____
Date_____
Witness_____

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Wish List - Reason for Visit

Today's date:_____
Name:_____

What issues and wishes do you want to discuss with Dr. Erb today?

_____
_____

When you like to accomplish your wish?

( ) ASAP ( ) 1 mo. ( ) 3 mo. ( ) 6 mo. ( ) 1 year

Would you be interest in learning more about any of the following procedures?

( ) Improvement in any skin conditions such as
- wrinkles
- loose skin
- brown spots
- scarring

( ) Fillers (Juvederm, Restylane,etc) to improve deep lines and to add youthful volume
- to hands
- to lower eyelids
- to temples
- to lips
- to other parts of face

( ) Botox	to improve or prevent wrinkles
( ) Kybella	to improve a double chin
( ) Laser skin resurfacing	to improve skin radiance, luminosity, spots, sun damage, and fine wrinkles
( ) Laser upper blepharoplasty	upper eyelid lift for a more refreshed appearance
( ) Laser lower blepharoplasty	improvement of lower eyelid bags for a more refreshed appearance
( ) Brow lift	to raise brows to a more youthful position
( ) Ptosis repair	to raise droopy eyelids
( ) Removal of bumps	to provide a smooth appearance
( ) Gel peel treatment facials	customizable peels to tighten, brighten, and hydrate
( ) Skin care	multifunctional products from organic to medical grade – to deliver optimal results

Patient signature_____ Reviewed by Erb_____

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Medical History

Today's date:_____
Name:_____

Current Medications:

Prescription medication: What for?

_____ _____
_____ _____
_____ _____
_____ _____

Eyedrops / Nasal Sprays: What for?

_____ _____
_____ _____

Over the counter meds / Herbal meds / Supplements:

_____
_____
_____

Allergies to medications: What happened?

_____ _____

Previous cosmetic surgery / Botox / Filler / Laser: When? By Whom?

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Other previous surgeries, including eye surgeries and LASIK:

_____
_____
_____

Past Trauma to the face:

_____

Wears contact lenses: YES___ NO___
Wears glasses: YES___ NO___

Medical History:	YES	NO
Environmental Allergies	___	___
High Blood Pressure	___	___
Diabetes	___	___
High Cholesterol or Triglycerides	___	___
Heart Disease	___	___
Liver Disease	___	___

Patient signature_____ Reviewed by Erb_____

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Today's date:_____
Name:_____

Medical History, continued:	YES	NO
Kidney Disease	___	___
Autoimmune / Rheumatological Disease	___	___
Stroke	___	___
Heart Attack	___	___
Irregular Heart Beat	___	___
Prolonged Bleeding	___	___
Easy Bruising	___	___
Respiratory problems	___	___
Obstructive Sleep Apnea / Snoring	___	___
Fainting	___	___
Bell's Palsy	___	___
Eye problems	___	___
Dry Eye	___	___
Tearing problems	___	___
Skin problems	___	___
Keloids	___	___
Post Inflammatory Hyperpigmentation	___	___
Oral herpes simplex	___	___
Accutane use	___	___
Hydroquinone use	___	___
Valvular heart disease	___	___
Bacterial endocarditis	___	___
Collagen vasular disease (lupus, scleroderma)	___	___
Immunological disorder (vitaligo, thyroiditis)	___	___
HIV / AIDS	___	___
Hepatitis A, B, and/or C	___	___
Psychological problems	___	___

Social History:

Occupation _____
Alcohol Use YES___ NO___ Type of alcohol_____ How often_____
Tobacco Use YES___ NO___ How many per day_____ How many years_____
Drug use YES___ NO___

Skin Typing assessment quiz results (see quiz attached)_____

Ethnicity / Ancestry / Heritage_____

Patient signature_____ Reviewed by Erb_____

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Today's date:_____
Name:_____

Review of Systems:
Any other active problems,
not previously mentioned or listed above,
related to:

	YES	NO	IF YES, PLEASE EXPLAIN
Constitutional (e.g., fever, weight loss)	___	___	
Eyes	___	___	
Ears, Nose, Mouth, Throat	___	___	
Cardiovascular	___	___	
Respiratory	___	___	
Gastrointestinal	___	___	
Genitourinary	___	___	
Musculoskeletal	___	___	
Integumentary (skin and/or breast)	___	___	
Neurological	___	___	
Psychiatric	___	___	
Endocrine	___	___	
Hematologic/Lymphatic	___	___	
Allergic/Immunologic	___	___	

Family history:
(mother, father, grandparents, siblings only)

	YES	NO	IF YES, WHO
Heart disease	___	___	
High blood pressure	___	___	
Diabetes	___	___	
Autoimmune / Rheumatologic disease	___	___	

Patient signature_____ Reviewed by Erb_____

HIPAA Notice of Privacy Practices

Melanie Ho Erb, M.D., Inc.
16300 Sand Canyon Avenue, Suite 1007
Irvine, CA 92618
949-727-0102

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ **Signature**_____ **Date**_____

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16300 Sand Canyon Ave., Suite 1007, Irvine, CA 92618
Phone 949.727.0102 · Fax 949.753.0291

PATIENT PHOTOGRAPHIC AUTHORIZATION & RELEASE

I, _____
Name of Patient
hereby authorize Melanie Erb, M.D. and/or staff to photograph me while under the care of Melanie Erb, M.D. I agree that the photographs may be used for my medical chart, patient education, scientific publications, and promotional materials.

_____

_____

I agree to hold harmless Melanie Erb M.D., her agents and employees, from any liability resulting from or arising in connection with the taking, publication and release of these photographs. I understand that I have the right to revoke this authorization in writing at anytime.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Melanie Erb, M.D.

_____
Signature of patient

_____
Signature of Witness

_____
Date