

**UNIVERSITY OF CALIFORNIA, SAN DIEGO  
DIVISION OF PLASTIC AND RECONSTRUCTIVE SURGERY**

Patient Registration

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Last name                      First name                      middle initial

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Sex : \_\_ male \_\_ female      Marital Status: \_\_ single \_\_ married \_\_ widowed \_\_ separated \_\_ divorced

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Are You Currently Working? \_\_ Yes \_\_ No

Email address: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

In Case Of Emergency, Who Should Be Notified? \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Pager/cellular) \_\_\_\_\_

Relationship To Patient: \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

PRIMARY Insurance Company Name: \_\_\_\_\_

Policyholder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Ins. Co. Phone Number: \_\_\_\_\_ Ins. Co Fax # \_\_\_\_\_

Policy/Id #: \_\_\_\_\_ Group #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

IF POLICYHOLDER IS SOMEONE OTHER THAN PATIENT, COMPLETE THE FOLLOWING:

Policyholder Birthdate: \_\_\_\_\_ Policyholder Soc. Sec.# \_\_\_\_\_

Policyholder Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Policyholder Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

SECONDARY Insurance Company Name: \_\_\_\_\_

Policyholder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Ins. Co. Phone Number: \_\_\_\_\_ Ins. Co Fax # \_\_\_\_\_

Policy/Id #: \_\_\_\_\_ Group #: \_\_\_\_\_

**IF POLICYHOLDER IS SOMEONE OTHER THAN PATIENT, COMPLETE THE FOLLOWING:**

Policyholder Birthdate: \_\_\_\_\_ Policyholder Soc. Sec.# \_\_\_\_\_

Policyholder Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Policyholder Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

**PATIENTS WITHOUT MEDICAL INSURANCE**

I, the undersigned, certify that I am responsible for all charges incurred for medical services rendered to me or my dependents by the physicians of UCSD Plastic and Reconstructive Surgery. I understand that payment in full is required at each appointment. My preferred method of payment is:

\_\_\_ Cash \_\_\_ Personal checks \_\_\_ Credit card (Visa or MasterCard)

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date

**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_  
(name of insurance co.)

and assign directly to UCSD Plastic and Reconstructive Surgery all insurance 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. I hereby authorize the doctor to release all information necessary to secure payment of benefit. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Signature of insured/responsible party

\_\_\_\_\_  
Date

**UNIVERSITY OF CALIFORNIA, SAN DIEGO**  
**DIVISION OF PLASTIC AND RECONSTRUCTIVE SURGERY**

*New Patient History Form*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Reason for today's visit: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex: \_\_\_ male \_\_\_ female Age: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

If you were referred by an emergency room, which one? \_\_\_\_\_

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

Current medications: \_\_\_\_\_

Vitamins / Herbal supplements: \_\_\_\_\_

Do you have any drug allergies? \_\_\_yes \_\_\_no (if yes, please list) \_\_\_\_\_

When was your last tetanus shot? \_\_\_\_\_ Was it within the past 5 years? \_\_\_yes \_\_\_no

Please circle all of the items below to which you have had an allergic reaction:

Aspirin            Iodine            Latex rubber            Local anesthetics (e.g. novocaine)

Do you smoke? \_\_\_yes \_\_\_no (if yes, how much) \_\_\_\_\_ Do you use recreational drugs? \_\_\_yes \_\_\_no

Do you drink alcohol? \_\_\_yes \_\_\_no (if yes, how much) \_\_\_\_\_

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

Please circle any of the following conditions you currently have or have had in the past:

- |                       |                           |                                |
|-----------------------|---------------------------|--------------------------------|
| AIDS or HIV infection | Epilepsy/convulsions      | Liver disease                  |
| Anemia                | Fainting/seizures         | Low blood pressure             |
| Angina                | Fever blisters            | Mental illness                 |
| Arthritis             | Glaucoma                  | Mitral valve prolapse          |
| Asthma                | Heart attack              | Psychological problems         |
| Cancer                | Heart disease             | Radiation therapy              |
| Cardiac pacemaker     | Heart murmur              | Respiratory/breathing problems |
| Chest pain            | Hepatitis/jaundice        | Rheumatic fever                |
| Cold sores            | High blood pressure       | Stroke                         |
| Depression            | Joint replacement/implant | Substance abuse                |
| Diabetes              | Kidney disease            | Suicide attempts               |
| Emphysema             | Leukemia                  | Thyroid problems               |

Please list any other major medical conditions you would like to bring to the physician's attention that was not listed above \_\_\_\_\_

*CONTINUED ON NEXT PAGE*

**UNIVERSITY OF CALIFORNIA, SAN DIEGO  
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*New Patient History Form, continued*

Please circle any of the following conditions that have occurred in your family:

Anesthesia reaction	Heart disease
Asthma	High blood pressure
Cancer	Lung disease
Diabetes	Melanoma
Eczema	Skin cancer

Have you seen another physician for the same reason you are here today? \_\_\_yes \_\_\_no

*For women only:*

Are you pregnant or think you may be pregnant? \_\_\_yes \_\_\_no

Are you nursing? \_\_\_yes \_\_\_no

Are you taking oral contraceptives? \_\_\_yes \_\_\_no

Do you perform self-breast exams? \_\_\_yes \_\_\_no

I certify that all of the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date

**UCSD MEDICAL CENTER  
PRIVACY PRACTICES**

As a new patient at UCSD Plastic and Reconstructive Surgery, you will be given a copy of the UCSD Medical Center Notice of Privacy Practices. After you have received and read this notice, you will be asked to sign a form to indicate that you have read and reviewed this privacy notice.

We reserve the right to change UCSD Medical Center's privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at UCSD Medical Center. The Notice will contain the effective date on the first page in the top right-hand corner. In addition, at any time you may request a copy of the current Notice in effect.

A copy of the Notice of Privacy Practices is available online in English at <http://health.ucsd.edu/hipaa/hipaa.asp> and in Spanish at [http://health.ucsd.edu/hipaa/hipaa\\_sp.asp](http://health.ucsd.edu/hipaa/hipaa_sp.asp).