KAREN K. LEONG, MD

PLASTIC SURGERY & FEMI-SURGICAL ENHANCEMENT

PLEASE ANSWER ALL QUESTIONS

NAME _____
last first middle initial

PATIENT'S SOCIAL SECURITY # _____ AGE _____ DOB _____

HOME ADDRESS _____
street apt number

_____
city state zip code

HOME (_____)_____ CELL (_____)_____ WORK (_____)_____

BEST CONTACT NUMBER (Please circle one) HOME / CELL / WORK

E-MAIL _____ CAN WE EMAIL YOU ? YES NO

EMPLOYER _____ OCCUPATION _____

NAME OF SPOUSE / PARENT / RESPONSIBLE PARTY (if other than patient) _____

HOME (_____)_____ CELL (_____)_____ WORK (_____)_____

EMERGENCY CONTACT _____

RELATIONSHIP _____ PHONE(_____)_____

INSURANCE INFORMATION: There are certain procedures that may be billable to your insurance if you have a PPO insurance plan. Please provide your card to our receptionist if you are here for medical reasons and not cosmetic.

REFERRED BY (Please circle one) MD / FRIEND / FAMILY / OTHER _____

HAVE YOU CONSULTED WITH ANOTHER PHYSICIAN? IF SO WHO _____

PRIMARY PHYSICIAN _____

REASON FOR CONSULTATION (LIST ALL) _____

SELF PAY

I will be responsible for services rendered by Karen K. Leong M.D. I agree to pay the full and entire amount for services rendered.

_____ _____

PATIENT/GUARANTOR SIGNATURE DATE

DATE OF YOUR LAST PHYSICAL EXAMINATION _____

WEIGHT _____ **HEIGHT** _____

SURGERY (OPERATIONS AND PLASTIC SURGERY)

	TYPE	DATE	COMPLICATIONS OR DIFFICULTIES
1.			
2.			
3.			
4.			

ADMISSIONS TO HOPSITAL

	REASON	DATE	COMPLICATIONS OR DIFFICULTIES
1.			
2.			
3.			

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE NOW

	TYPE	DOSAGE/AMOUNT IF KNOWN	TAKE HOW OFTEN
1.			
2.			
3.			

CONSUMPTION OF THE FOLLOWING

ASPIRIN _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

ALCOHOL _____ AMOUNT DAILY_____ AMOUNT WEEKLY _____

TOBACCO _____ AMOUNT DAILY_____ AMOUNT WEEKLY _____

OTHERS _____ AMOUNT DAILY_____ AMOUNT WEEKLY _____

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA

EXPLAIN _____

ARE YOU PREGNANT YES NO

BIRTHS (QUANITY AND LIST VAGINAL OR CESAREAN) _____

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

MOTHER_____ SISTER _____

FATHER _____ BROTHER _____

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS? PLEASE LIST ALL _____

_____ _____

PATIENT/GUARANTOR SIGNATURE DATE

Are you currently, or have you had, problems with:

CONSTITUTIONAL	Circle One	
Weight Gain	YES	NO
Weight Loss	YES	NO
Night Sweats	YES	NO
Insomnia	YES	NO

EYES		
Double Vision	YES	NO
Visual Loss	YES	NO

EAR, NOSE THROAT AND MOUTH		
Hearing Loss	YES	NO
Noise/Ringing in ears	YES	NO
Nasal Congestion	YES	NO
Sore Throat	YES	NO
Trouble Swallowing	YES	NO
Hoarseness	YES	NO

CARDIOVASCULAR		
Chest Pain or Angina	YES	NO
Heart Trouble	YES	NO
Rheumatic Fever	YES	NO
Heart Murmur	YES	NO
High Blood Pressure	YES	NO

NEUROLOGICAL		
Numbness	YES	NO
Weakness	YES	NO
Stroke	YES	NO
Headache	YES	NO

PSYCHIATRIC		
Depression	YES	NO
Any other treatment_____	YES	NO

ALLERGIC/IMMUNOLOGIC		
Sneezing	YES	NO
Itchy Eye/Nose	YES	NO
Itchy Throat	YES	NO
Skin Rash	YES	NO
HIV	YES	NO
Hepatitis B or C	YES	NO

RESPIRATORY	Circle One	
Asthma	YES	NO
Cough up Blood	YES	NO
TB	YES	NO
Pneumonia	YES	NO
Trouble Breathing At Night	YES	NO
Snoring	YES	NO

GASTROINTESTINAL		
Indigestion or Heartburn	YES	NO
Ulcer	YES	NO
Hepatitis	YES	NO
Jaundice	YES	NO
Blood in Stool	YES	NO
Black, Tarry Stools	YES	NO

GENITOURINARY		
Bladder Trouble	YES	NO
Prostate Disease	YES	NO
Kidney Disease	YES	NO

MUSCULOSKELETAL		
Arthritis	YES	NO

ENDOCRINE		
Diabetes	YES	NO
Thyroid Disease	YES	NO

HEMATOLOGIC		
Bleeding Disorder	YES	NO
Easy Bleeding	YES	NO

FEMININE HEALTH		
Menopause	YES	NO
Hormone replacement	YES	NO
Breast cancer	YES	NO
Cervical/endometrial cancer	YES	NO
Stress urinary incontinence	YES	NO

OTHER

Would you accept blood in an emergency? Y/N
Have you ever used Phen-fen? Y/N
Do you have any other disease or problem not listed here? Y/N

I have reviewed the above information with the patient.

Karen K. Leong, MD

The above information is accurate to the best of my knowledge.

Patient Signature

Date

AREAS OF INTEREST

Please check any of the following that bother you about your skin face or body.

Skin

□ Wrinkles □ Brown Spots □ Acne □ Uneven Tone & Texture
□ Redness □ Rosacea □ Scars □ Dry Skin
□ Oily Skin □ Loose Skin

Face

□ Drooping Brow □ Thin Lips □ Aging Neck □ Puffy, Dark or Drooping Eyelids
□ Sagging Skin □ Unwanted Hair □ Thinning Hair □ Loss Of Volume In Cheeks

Body

□ Unwanted Hair □ Aging Chest □ Aging Hands □ Excess Fat
□ Spider Veins □ Cellulite □ Excess or Loose Skin □ Breast Sagging or Volume Loss

Feminine Health

□ I have children □ I would like my body back the way it was before children
□ Vaginal Dryness □ Pelvic Pain
□ Incontinence (Spontaneous Urination) □ Loss of Sensation or Pleasure

IF YOU DO NOT SEE YOUR CONCERN ABOVE, TELL US!:

_____

_____

PATIENT PHOTOGRAPH RELEASE FORM

Patient's name _____

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of the medical staff. I hereby give my consent for Karen K Leong, MD to use the photographs under one of the following circumstances:

Please initial:

AMERICAN BOARD OF PLASTIC SURGERY

_____I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. The Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy.

Please initial **JUST ONE** of the following:

ALL MEDIA

_____ Photographs taken of me or parts of my body as well as details regarding medical service I have may be used in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, our internet site and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Karen K Leong, MD, the facility used, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including claim for payment in connection with any such user or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

WEBSITE ONLY

_____ Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used on our website in order to inform the public about plastic surgery methods. Further, I release and discharge Karen K Leong, MD, the facility used, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including claim for payment in connection with any such user or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

PHOTO ALBUM ONLY

_____ Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used in the photograph album in order to inform other plastic surgery patients about plastic surgery methods. Further, I release and discharge Karen K Leong, MD, the facility used, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including claim for payment in connection with any such user or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

MEDICAL ONLY

_____ Photographs taken of me or parts of my body can be solely used for the purpose of my medical care with Karen K Leong, MD. The photographs and details regarding medical services rendered to me will be kept confidential within my personal medical file.

Signature Date / /

PHYSICIAN- PATIENT ABRITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** I is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submissions to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract, or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners associates, associates, corporations, partnerships employees agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both other and the mother's expected child or children.

Filing by Physician of any action in any curt by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages south, and the names, addresses and telephone numbers of patient, and (if applicable) his/her attorney, The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge to presides over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure & 1280-1295 and the Federal Arbitration Act (9 U.S.C. && 1-4) The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the agreement enforced in accordance with California law. I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:_____
Physician's or Duly (Date)
(Date)

By: _____
Patient's Signature

_____
Print Patient's Name

By: Dr. Karen Leong
Print or Stamp Name of Physician,

By:_____ Medical

By: _____
Signature of Translator (if applicable) (Date)

_____
Print Name of Translator

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical record.