

VINCENT C. HUNG, M.D., F.A.C.S., INC.
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Patient Consent for Use and Disclosure of Protected Health Information

The purpose of this form is to comply with the Federal Government mandate to protect patient privacy.

With my consent, Vincent C. Hung, M.D., may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Vincent C. Hung, M.D.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Vincent C. Hung, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Vincent C. Hung, M.D. Group Privacy Officer at 1501 Superior Ave., Suite 208, Newport Beach, California 92663.

With my consent, Vincent C. Hung, M.D. may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, Vincent C. Hung, M.D. may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and correspondence.

Signed _____ Date _____
(Patient or authorized person)

INFORMATION FOR CASE HISTORY FILE

(PLEASE COMPLETE ALL ITEMS – PLEASE PRINT)

Date: _____

SS#: _____

Patient's name: _____ Age: _____ Date of birth: _____ Sex: _____

Home address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Married: _____ Single: _____ Widowed: _____ Divorced: _____ Separated: _____

Patient's Occupation: _____ Employer _____

Business address: _____ Business phone: _____ Ext: _____

Name of Spouse: _____ Spouse's Occupation _____

Spouse's Employer: _____ Address: _____ Business Phone _____

Patient Referred by: _____ Phone Number: _____

Address: _____

Nearest Relative and Address: _____ Phone Number: _____

(Relative not living at same address as patient)

Insurance Company: _____ Group No. _____ Policy No. _____

Social Security Number of Policy Holder: _____ Medicare No. _____

How do you wish to pay today's visit? Cash: _____ Check: _____ MasterCard/Visa: _____

If person completing this form is someone other than patient (spouse, parent, guardian, etc.) or if patient is a minor please complete the following:

Name: _____ Relationship: _____
(Party financially responsible)

Address: _____
(Street) (City) (State) (Zip)

Occupation: _____ Employer _____

Business Address: _____ Business Phone: _____

Have you had significant complications or after effects from any of these operations? Yes _____ No _____

If "Yes", please explain _____

INJURIES

Type	Year	Hospital	Doctor	After Effect
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FAMILY HISTORY

	Age	State of Health	HAS ANY RELATIVE HAD:	
Mother	_____	_____	Tuberculosis	No ___ Yes ___
Father	_____	_____	Cancer	No ___ Yes ___
Brother(s)	_____	_____	Diabetes	No ___ Yes ___
Sister(s)	_____	_____	Epilepsy	No ___ Yes ___
Children	_____	_____	Heart Disease	No ___ Yes ___
_____	_____	_____	High Blood Pressure	No ___ Yes ___
_____	_____	_____	Lung Disease	No ___ Yes ___
_____	_____	_____	Kidney Disease	No ___ Yes ___
			Blood or Bleeding Disorders	No ___ Yes ___
			Asthma	No ___ Yes ___
			Mental Disease	No ___ Yes ___

MEDICATIONS & DRUGS

What is your approximate daily consumption of the following:

Coffee or Tea _____ Alcohol _____ Tobacco _____

Other intoxicating or mind altering drugs (specify) _____

Does anyone else in your household smoke? No _____ Yes _____ How much? _____

Have you had excessive bleeding requiring treatment? _____

Are you taking any medications including aspirin or anti-inflammatories? _____

Please list **ALL** your medications and their dosages (including **BIRTH CONTROL PILLS, DIURETIC** (water pills), **BLOOD PRESSURE** or **HEART MEDICATIONS, TRANQUILIZERS, HORMONES, BLOOD THINNERS, NOSE DROPS/SPRAYS, INHALER MEDICATIONS, RUB-ON MEDICATIONS** (liniments). **ASPIRIN, BUFFERIN, ETC...**

PERTINENT PREOPERATIVE INFORMATION

Are you allergic to any medication? Yes ___ No ___

If "Yes", which one (s)? _____

Have you every reacted badly to being put to sleep for surgery? No ___ Yes ___

Has any member of your family every reacted badly to being put to sleep for surgery? No ___ Yes ___

Have you required unusually large amounts of local anesthetic for medical or Dental procedures? No ___ Yes ___

Have you ever had a bad reaction to a local anesthetic (Novovaine, etc...)? No ___ Yes ___

Are you allergic to adhesive tape? No ___ Yes ___

Are you allergic to suture material such as catgut? No ___ Yes ___

Do you have high blood pressure? No___ Yes___

Have you ever had scarlet fever or rheumatic fever? No___ Yes___

Do you bleed unusually easily (from cuts, surgery, tooth extractions)? No___ Yes___

Do you bruise unusually easily? No___ Yes___

Are you a slow or poor healer? No___ Yes___

Do you form large scars or keloids? No___ Yes___

Do you have any skin disease, hives, eczema or rash? No___ Yes___

Do you have frequent infection or boils? No___ Yes___

Have you taken steroid medication, cortisone, or ACTH? If so, how long ago? No___ Yes___

Do you have shortness of breath when walking? No___ Yes___

Do you have, or have you had, any back trouble? No___ Yes___

Does your religion prohibit blood transfusions No___ Yes___

Do you have, or have you had, any significant emotional problems? No___ Yes___

Have you ever had, or been advised to seek psychiatric care? No___ Yes___

Have you had any illnesses or disorders of the following: (Circle if Yes)

Brain (Including Strokes, Epilepsy)	Face (Paralysis)	Heart or Blood Vessels	Blood	Arm or Legs
Nervous System	Nose, Sinuses, Throat	Stomach	Urinary System	Bones & Joints
Eyes (Including Glaucoma, Dryness)	Breast	Intestines	Reproductive System	Endocrine System
Ears	Lungs (Including Asthma)	Liver	HIV/AIDS	

If circled, please explain: _____

Authorization to permit treatment photos to be taken and or used for educational purpose:

Patient or parent signature: _____

ACKNOWLEDGMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of person named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay them in full at the time of service, unless other arrangements as made with the Financial Department.

Signed _____ (Patient, Parent or Agent (must be 18 years or older))