AUTHORIZATION TO TREAT

DR. BRYAN McINTOSH
Refining Natural Beauty

I _____, hereby authorize Puget Sound Plastic Surgical Group, PLLC and associates to provide me with medical treatment as may be deemed necessary or advisable in the judgment of the physician or other providers. This treatment includes, but is not limited to, physical examination, medical and surgical treatments or procedures, anesthesia or other services rendered to the patients under the general and specific instructions of the physician. I agree to inform the staff and/or physician if I have any concerns about my medical treatment or costs prior to services being rendered.

I _____, the parent/guardian of _____, give Puget Sound Plastic Surgical Group, PLLC and associates the right to provide my son/daughter or legal ward with medical treatment as may be deemed necessary or advisable in the judgment of the physician or other providers. This includes, but is not limited to, physical examination, medical and surgical treatments or procedures, anesthesia or other services rendered to the patients under the general and specific instructions of the physician. I agree to inform the staff and/or physician if I have any concerns about such medical treatment or costs prior to services being rendered.

General Agreement: I recognize that the practice of medicine and surgery is not an exact science. I understand and accept that fees are paid for performance of the procedure(s) only, and not a guaranteed result. I acknowledge that although a good outcome is expected, and a reasonable effort has been made to establish realistic expectations, there cannot be any warranty, expressed or implied, as to the results that may be obtained. I understand and accept that problems relating to or complications of my care, treatment, procedure(s) or surgery may result in additional costs to me. These costs may include additional anesthesia and facility fees, hospital costs, physician's fees or other unspecified charges that may not be covered, or only partially covered, by my health insurance.

Release of Information: The medical records concerning patient care are the property of Puget Sound Plastic Surgical Group, PLLC and are maintained for the benefit of the patient, the medical staff and the Group. I certify that the information given by me for billing of my insurance is accurate and complete. I hereby authorize Puget Sound Plastic Surgical Group, PLLC to release information and/or copies of my medical records to physicians, any guarantor of payment on my account, and insurance companies for which I have assigned benefits for my treatment of care. This authorization includes but is not limited to release of information pertaining to serologic test results (including but not limited to Acquired Immune Deficiency Syndrome or positive HIV results), pathology results, radiology results and any other information. I authorize the provider to use all available means of communication to transmit such information, including but not limited to electronic mail or electronic fax transmissions.

Use of Records and Photographs for Examination Purposes: I hereby grant permission for the use of any of my medical records including, but not limited to, 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.

Use of Photographs for Advertising, Marketing and Educational Purposes: I hereby grant permission for the use of any of my illustrations, photographs, videos or other imaging records created in my case by Puget Sound Plastic Surgical Group, PLLC and associates for the purposes of written, printed, electronic, internet and any other forms of advertising, marketing and education. I understand that identifiable characteristics may not necessarily be blanked out.

Communication: I understand that electronic forms of communication are not secure or encrypted. However, if I provide my email address, I authorize all electronic communication regarding issues such as my medical diagnoses, treatment, instructions, billing issues, marketing, advertisements and the like. I also agree to receive emails regarding promotions, events, special pricing and the like. I agree that all telephone numbers I provide may be used to contact me regarding appointments, laboratory results and debt collection.

Payment Responsibility: I understand and authorize that certain insurance claims may be filed as a courtesy to me, that insurance is considered a method of reimbursing the physician for some services rendered to the patient, and that some companies pay fixed allowances for certain procedures while others pay a percentage of the charges. I understand that it is my responsibility to pay any co-pay at the time of service; I am to pay any deductible, coinsurance, or any other balance not paid for by my insurance or third party payor within sixty days from the date of service or my balance will be turned over to a collections agency. I understand I will be responsible for all fees incurred in attempts to collect my unpaid balance including but not limited to those incurred by billing agencies, collection agencies, courts, and attorneys. If I am married, the marital community is obligated to pay for services rendered to me. I may direct Puget Sound Plastic Surgical Group to seek payment, preauthorization or precertification for past or future consultations, treatments, procedures and/or surgeries that initially were deemed by me or the doctor to be not medically necessary; I understand my insurance may not provide reimbursement for such services, and that I will then be fully responsible for all charges billed but not reimbursed by my insurance company. **Regardless of my insurance or third party payor, until co-pays, deductibles and coinsurances are**

satisfied, my insurance is verified, or if Bryan C. McIntosh, MD does not participate with my insurance or third party payor, I am considered a Private-Self Pay patient (see below).

Credit Cards, Debit Cards and Financing: It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Puget Sound Plastic Surgical Group, PLLC to use and disclose my protected health information to any credit card entity, bank, or financing company when they request such information to process an account and assist with payment. I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this non credit card challenge agreement is irrevocable.

Assignment of Benefits: I assign payment directly to Puget Sound Plastic Surgical Group, PLLC for benefits otherwise payable to me for services rendered.

Worker's Compensation/L&I: I am responsible for getting authorization through my employer and to obtain workers compensation billing information.

Auto Accident or Liability Insurance: If I have been involved in an auto accident, I am required to provide Puget Sound Plastic Surgical Group, PLLC a copy of the accident report, my coverage selection page, auto policy and health insurance information. If an attorney is involved, I must return the doctor's lien form within ten business days.

Private-Self Pay: Payment is expected at time of service in the form of **Cash or Credit/Debit Cards.**

Medicare: If insured under Medicare, I certify that the information given by me in applying for payment under the appropriate titles of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Medicaid/DSHS: I am aware that Bryan C. McIntosh, MD is not contracted with Medicaid/DSHS, that I am financially responsible for all charges, and that payment is due and payable in full at the time of service.

Referrals: I understand that it is my responsibility to ensure that, if required by my insurance carrier, a referral is obtained prior to seeing anyone at Puget Sound Plastic Surgical Group, PLLC for medical or surgical care. If I do not obtain a referral if required by my insurance carrier, I am responsible for all charges for care provided by Puget Sound Plastic Surgical Group, PLLC.

Out of Network Care: I understand that Puget Sound Plastic Surgical Group, PLLC is not a participating provider with all insurance carriers, that my cost for services will either be reimbursed at a lower rate or not at all, and that I am wholly responsible for payment of any amount not reimbursed by my insurance carrier.

Additional Medical Care: I understand that if symptoms persist I should seek additional medical care.

Missing Appointments: I understand that I am required to provide a minimum advanced notice of 24 hours prior to canceling or rescheduling any appointment. Failure to do so will result in a charge of $50 per occurrence, and I am solely responsible for paying this charge.

Revision Policy: Additional treatments, touch-ups, and modifications or revisions to prior treatments or results may be required, as no results are guaranteed. Additional treatments using consumable products (such as, but not limited to, Botox, Juvéderm, Dermaroller, and the like) must be paid for prior to their additional use. Surgical revisions deemed necessary by the physician will be done possibly at a reduced surgeon's fee, but facility and anesthesia fees will be the responsibility of the patient. If the revision can be completed in our procedure room, the facility fee of $450 per hour will be assessed, with a minimum charge of $450.

Acknowledgement of Receipt of Office Privacy Policies/Practices: I acknowledge that I was provided a copy of the Privacy Policies and that I have read (*or had the opportunity to read if I so chose*) and understood and agree with the privacy policies.

I have read, understand, and agree to all of the terms of this Authorization to Treat form.

Patient or Legal Representative Signature / Date	Relationship (self, parent, etc.)
Print Patient or Legal Representative Name	Witness Signature / Date

PRIVACY POLICIES

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, and the Omnibus Rule of 2013. The terms of this notice apply to all records containing your Protected Health Information (PHI) that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to any other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you.

8. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect

- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

6. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

8. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

9. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

10. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

YOUR RIGHTS REGARDING YOUR PHI
You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Arthur H. Gee, Jr. at PO Box 723, Kirkland, WA 98083 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Arthur H. Gee, Jr. at PO Box 723, Kirkland, WA 98083. Your request must describe in a clear and concise fashion:

1. the information you wish restricted;
2. whether you are requesting to limit our practice's use, disclosure or both; and
3. to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Arthur H. Gee, Jr. at PO Box 723, Kirkland, WA 98083 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Arthur H. Gee, Jr. at PO Box 723, Kirkland, WA 98083. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Arthur H. Gee, Jr. at PO Box 723, Kirkland, WA 98083. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Arthur H. Gee, Jr. at PO Box 723, Kirkland, WA 98083.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Arthur H. Gee, Jr., Privacy Officer, (425) 420-2663. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

If you have any questions regarding this notice or our health information privacy polices, please contact Puget Sound Plastic Surgical Group, PLLC at (425) 420-2663.

Demographics

DR. BRYAN MCINTOSH
Refining Natural Beauty

PT. NAME _____ M ____ F ____ DOB _____ AGE _____
Last First MI
SOCIAL SECURITY # _____
ADDRESS _____ YOUR OCCUPATION _____
CITY/STATE _____ ZIP _____ YOUR EMPLOYER _____
HOME PHONE ( ) _____ SPOUSE'S NAME _____ DOB _____
WORK PHONE ( ) _____ SPOUSES OCCUPATION _____
CELL PHONE ( ) _____ SPOUSES EMPLOYER _____
ETHNICITY _____ PREFERRED LANGUAGE _____ E-MAIL: _____
REFERRED BY **PRIMARY CARE PHYSICIAN**

PRIMARY INSURANCE _____ **SECONDARY INSURANCE** _____
Insured _____ DOB _____ Insured _____ DOB _____
Employer _____ Employer _____
Relationship to patient _____ Relationship to patient _____
Insured ID No. _____ Insured ID No. _____
Group No. _____ Group No. _____
L & I Claim # _____ Date of Injury _____ Employer time of injury _____
Does your insurance require preauthorization before hospitalization or procedures? **YES** ☐ **NO** ☐
If YES, phone number to call:

BILLING: If person responsible for bill is **other than above patient,** please complete.

NAME _____ SS# _____
Last First MI
OCCUPATION _____
Relationship to patient _____ EMPLOYER _____
ADDRESS _____ ADDRESS _____
CITY/STATE _____ ZIP _____ CITY/STATE _____ ZIP _____
HOME PHONE ( ) _____ WORK PHONE ( ) _____

EMERGENCY INFORMATION: Person to contact in case of emergency, not living at the above address.
NAME _____ PHONE _____ RELATIONSHIP _____

INTERPRETER INFORMATION: In case we need to notify patient or pass on a message.
NAME _____ PHONE _____

1. I authorize treatment of the person named above and agree to pay all fees for such treatment.
2. I hereby authorize Puget Sound Plastic Surgical Group, PLLC to receive all benefits to which my dependents or I are entitled under my health insurance plan. IN addition, I will not withhold or delay payment if my insurance company denies payment on any of my charges. I acknowledge there is a $35 fee on checks returned from my bank. Should the balance of the account exceed an amount the undersigned is able to pay in full, an agreed payment plan can be established with 1% interest per month on the unpaid balance.
3. I authorize Puget Sound Plastic Surgical Group and associates to release any medical information acquired in the course of my examination or treatment to process my insurance claims.
4. All of the information on this form is complete and accurate.

SIGNATURE _____ RELATIONSHIP TO PATIENT _____
DATE _____

Medical and Surgical History

DR. BRYAN MCINTOSH
Refining Natural Beauty

Name _____

Today's Date _____

Reason for Visit _____

Are you in good health? YES NO If no, provide reason _____

Height _____ Weight _____ Greatest Weight and Date _____

Medical History: List all current medical problems you have or are being treated for and all diagnoses ever made by a physician and date of diagnosis

_____

_____

_____

Surgical History: List all surgeries or procedures ever performed on you and their dates

_____

_____

_____

Occupation _____ Marital Status _____ Children (#) _____

Smoking YES NO Age you started smoking _____ Packs per day _____ Age you quit _____

Caffeinated beverages YES NO Type _____ Amount/Frequency _____

Alcoholic beverages YES NO Type _____ Amount/Frequency _____

Drugs YES NO Type and frequency _____

Family medical/surgical history: List all health problems you know of associated with your parents, siblings, and children

_____

Have any of your relatives ever had a problem with anesthesia? Please describe _____

Allergies (foods, medications, environmental, pets) _____

List all medications which you are currently or have taken in the last 6 months (prescription and non-prescription)
Medication(s) (ESPECIALLY ASPIRIN) Amount: Frequency:

_____

_____

_____

_____

Vitamins, minerals, herbal supplements (such as Gingko, Ginger, Garlic, St. John's Wort, fish oil, flax seed oil)

_____

_____

Puget Sound Plastic Surgical Group, PLLC | Dr. Bryan McIntosh, *Plastic Surgeon*
12301 NE 10th Pl, Ste 101, Bellevue, WA 98005 | *Phone* (425) 420-2663 *Fax* (425) 409-6262

Circle any items that apply to you and explain why:

General: Change in weight, health status, strength or exercise tolerance, fever, chills, fatigue, weakness

Head: Headaches, vertigo, injury

Eyes: Vision problems, corrective lenses, double vision, lack of / excessive tearing, itchy eyes flashes of light, specks, glaucoma, cataracts, eye pain, **last eye exam**

Ears: Hearing problems, ringing in the ears, bleeding from the ears, drainage

Nose: Nosebleeds, nasal discharge, obstruction, stuffiness, itching, seasonal allergies, sinus pain

Mouth: Dental difficulties, bleeding of gums, use of dentures, chipped/broken teeth, sore tongue, hoarseness, thrush, non-healing sores, difficulty opening mouth, **last dental exam**

Neck: Stiffness, pain, tenderness, masses, swollen glands

Breast: Lumps, tenderness, swelling, nipple discharge, asymmetry, **last breast exam by a physician, last mammogram**

Lungs: Shortness of breath, wheezing, painful breathing, bloody cough, dry / productive cough, sputum amount / color

Heart: Chest pains, tightness, palpitations, fainting, lightheadedness upon standing up, shortness of breath with activity, difficulty lying down, arm / leg swelling

Abdomen: Change in appetite, difficulty swallowing, heartburn, abdominal pains, changes in bowel habits, nausea, vomiting, bloody stool, rectal bleeding, constipation, diarrhea, yellow skin / eyes / jaundice

Genitourinary: Urinary urgency, incontinence, painful urination, change in nature/color of urine, blood in urine, genital itching, sores, masses, discharge, STDs, pain with sex, erectile dysfunction, vaginal dryness, hernia

Gyn: Change in menstruation, painful menstruation, excessive/frequent menstruation, vaginal discharge, pelvic pain

Musculoskeletal: Pain in muscles or joints, limitation of range of motion, weakness, stiffness, redness / swelling of joints, trauma

Skin: Open wounds, rashes, itching, dryness, discoloration, hair / nail changes history of sunburn, scarring problems

Hematological: Easy bleeding, easy bruising

Vascular: Calf pain with walking, leg cramping

Neurologic: Tremor, seizures, changes in thinking/memory, unsteady walking, tingling, numbness, **problems with anesthesia**

Endocrine: Heat / cold intolerance, sweating, thirst

Psychiatric: Depressive symptoms, nervousness, stress, changes in sleep habits, changes in thought content

I have completed this Medical and Surgical History form to the best of my ability, and the information is complete and accurate.

Patient or Legal Representative Signature / Date

Print Name of Patient or Legal Representative

Physician Signature / Date

Print Name of Physician

Cosmetic Questionnaire

DR. BRYAN MCINTOSH

Name _____

Date _____

Which additional services would you like to learn about? Please check all that apply.

❑ Skin care advice	❑ Brown spots/age spots/freckle	❑ Breast size
❑ Skin care products	❑ Drooping brow	❑ Abdominal area
❑ Injectable Treatments	❑ Drooping eyelids	❑ Hips
❑ Juvederm/Restylane/Radiesse	❑ Nose size or shape	❑ Legs
❑ Facial fine lines/wrinkles	❑ Facial fullness/drooping/jowling	❑ Facial Contouring
❑ Thin lips	❑ Mole removal	❑ Body Contouring
❑ Blotchy skin	❑ Scar revision	❑ Length/Fullness of Eyelashes
❑ Chemical peel	❑ Neck wrinkles	❑ Unwanted hair
❑ Nonsurgical facelift/rhinoplasty	❑ Botox and migraines	❑ Other:

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

How did you hear about us?

❑ My physician	*Full name and phone:*
❑ My insurance company provider	*Name:*
❑ A friend or family member	*Name:*
❑ The practice website	
❑ Internet	*Site:*
❑ Seminar	*Date/location:*
❑ Other	

❑ Please contact me via ❑email or ❑telephone with information regarding events, promotions and services.

❑ *I'm not interested in any additional services provided at this time*

↓ For Staff Use Only ↓

Physician / provider : BCM TRD DRW AHG

Follow-up	*Date*	*Completed by (name)*
❑ Initial Inquiry/Information Given		
❑ Contact in future – give date		
❑ Products		
❑ Free consultation		
❑ Procedure scheduled		
❑ Procedure completed		

Procedure: _____

Duration: 0.5 hour 1 hour 1.5 hours 2 hours 2.5 hours 3 hours 4 hours 5 hours 6 hours 7 hours 8 hours

Facility: Inpatient/Outpatient Evergreen Overlake Valley Edmonds First Hill Issaquah Belred Office

Additional services: Saline/Silicone Implants Bra Binder Garment Assistant _____

Puget Sound Plastic Surgical Group, PLLC | Dr. Bryan McIntosh, *Plastic Surgeon*

12301 NE 10th Pl, Ste 101, Bellevue, WA 98005 | *Phone* (425) 420-2663 *Fax* (425) 409-6262