EAST BAY HAND & PLASTIC SURGERY CENTER
PRASAD G. KILARU, M.D., M.B.A.
PLASTIC, RECONSTRUCTIVE, COSMETIC AND HAND SURGERY

CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY

39141 Civic Center Drive. Suite 110, Fremont CA 94538
Phone: (510) 791-9700 Fax: (510) 791-9703

COSMETIC PATIENT FORM

Date: _____

Name: _____ Phone: _____ (H)

Address: _____ Phone: _____ (C)

City: _____ State: _____ Zip: _____ Phone: _____ (W)

Email: _____

Date of Birth: ___/_____/_____ Age: _____

How did you hear about us? Internet _____ Referral_____ Other_____

In case of emergency, who should be notified? _____ (PH) _____

Primary Care Physician :_____(PH) _____

Do we have permission to:

Leave a message on your answering machine at home?	YES	NO
Leave a message at our place of employment?	YES	NO
Discuss your medical condition with a member of your household?	YES	NO
Send you information regarding promotions or specials we occasionally have? (We will always protect your information.)	YES	NO

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, 800-633-2322, www.mbc.ca.gov

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy Practices from time to time and

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that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

COSMETIC PATIENT FORM

Welcome to East Bay Hand and Plastic Surgery. Please complete as much of the information below as possible.

What brings you to our office? Please be specific

What medical problems do you have if any?

Please list any prior surgeries.

Do you have any allergies to medications?

If you are currently taking any medications please list medication sheet (Last page)

Do you currently smoke? YES NO If yes, how many packs per day?
How many years?

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Have you ever smoked? YES NO If yes, how many packs per day?
How many years

Do you drink alcohol? YES NO If yes, how much? How often?

Do you have relatives who have had breast cancer? YES NO If yes, relationship?

Do you have a problem with excessive scarring or keloid formation after being cut? YES NO

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PHOTOGRAPHY CONSENT

The Undersigned hereby consents to have photographs taken in the course of:

1. Pre-operative evaluation and planning
2. Intra-operative or procedural documentation or evaluation
3. Post –operative documentation or evaluation

The term “photograph” as used herein includes still photography, in digital or any other format, and any other means of recording or reproducing images.

The undersigned acknowledges understanding that photographs may be used in the course of treatment, research, educational and informational programs as my physician deems appropriate and that such use is subject only to the following limitations:

Date: _____ Time: _____

Signature: _____

Witness: _____