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

RECONSTRUCTIVE PATIENT FORM

Date: ___________________

Name: ____ Phone :_________________(H)

Address: ____ Phone: _________________(C)

City: _________________ State: _______ Zip: ________________ Phone: ________________ (W)

Email: ____ S. S. # ____________________

Date of Birth: _____/______/_____ Sex: M F Height__________ Weight __________

Employer: ____

Who referred you to this office: ____

In case of emergency who should be notified: _______________________Ph:______________________

Primary Care Physician: ____

Pharmacy Name: ____________________________Location:_________________ Phone:_____________

Insurance Information

Please have your insurance cards and your co-pay ready for the receptionist.

Primary Insurance _______________________________ Secondary insurance_____________________

Name of Insured _________________________________ Name of Insured ________________________

Insured's ID# ______________________________________ Insured's ID# ____________________________

Insured's Date of Birth______________________________ Insured's Date of Birth______________________

Group #____ Group #_________________________________

Relationship to Insured____

Do we have permission to:
Leave a message on your answering machine at home? YES NO
Leave a message at your place of employment? YES NO

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Discuss your medical condition with any member of your household? YES NO

Signature of patient or legal guardian__________________________________ Date: ____________________

RECONSTRUCTIVE PATIENT FORM

What brings you to this office? ____

How long have you had this condition? ____

Have you had previous treatment for this condition? ____
If yes, how and when____

Do you have or have you had any of the following? (Circle yes or no)

AIDS or HIV Positive	Yes	No	Hepatitis	Yes	No
Anemia	Yes	No	High Blood Pressure	Yes	No
Arthritis	Yes	No	Kidney Problems	Yes	No
Asthma	Yes	No	Migraine Headaches	Yes	No
Back problems	Yes	No	Nervous Breakdown	Yes	No
Blood clots	Yes	No	Nose/ Throat problems	Yes	No
Blood disorders	Yes	No	Pneumonia	Yes	No
Bleeding Problems	Yes	No	Psychiatric condition	Yes	No
Breathing Problems	Yes	No	Rheumatic Fever	Yes	No
Cancer	Yes	No	Seizures	Yes	No
Chest Pains	Yes	No	Shortness of breath	Yes	No
Colitis	Yes	No	Skin cancer	Yes	No
Diabetes	Yes	No	Stomach problems	Yes	No
Epilepsy	Yes	No	Stroke	Yes	No
Heart Problems	Yes	No	Thyroid problems	Yes	No
Heart Murmur	Yes	No	Tuberculosis	Yes	No
Heart palpitations	Yes	No	Transfusion	Yes	No

Family and Social History:

Current medical condition: ____
List any hospitalizations and/or surgeries and dates: ____
____
Are you allergic to any medications? ____

Have you had any allergic or bad reactions to local or general anesthesia? _________________________

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Are you taking any medications regularly? If yes please list on sheet provided. (Last page)

Do you currently smoke Yes No How may packs per day_____ how many years_______
Have you ever smoked Yes No How many packs per day ____ When quit____________
Do you drink alcohol Yes No If yes, how much ____________ How often__________
Do you have relatives who have had breast cancer? Yes No Who______________________
Have you ever had a mammogram Yes No When was the last one____________________
Do you have excessive scarring or keloid ____

CONTACT AUTHORIZATION

According to federal law our office must obtain authorization from you to send to you via email or regular mail information regarding our practice such as products we sell or any of the services the practice offers such as promotions, events or special discounts. Our office **Does Not** sell or share our patient's information.

I understand that my health care will not be affected if I do not sign this form. I have the right to receive a copy of this authorization. I also understand I may revoke or modify this authorization at any time by notifying East bay Hand and Plastic Surgery in writing. I must sign and date my written request and send it to:

East Bay Hand and Plastic Surgery
39141 Civic Center Dr. Suite 101
Fremont, CA 94538

I DO__________ I DO NOT____________

Authorize East Bay Hand and Plastic Surgery to use and disclose my Protected Health Information to mail me any information regarding services, products, and/or promotions the practice offers.

Patient Signature_______________________________________ Date:_____________________

Email Address ____

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

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Notice of Privacy Practices Acknowledgement

I understand that, under the health Insurance Portability & 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 its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Patient Name: ______________________________________Relationship to Patient___________________

Signature: ____ Date: _________________________