DR. SUZANNE YEE
Cosmetic & Laser Surgery Center
TRIPLE-BOARD CERTIFIED

Today's Date:_____

Patient Name:_____
First Middle Last

Address: _____
Street & Apt # City State Zip

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

DOB: ____/___/_____ **SS #** _____-_____-_____ **Gender:** ☐ Female ☐ Male ☐ Non-Binary

Marital Status: ☐ Single ☐ Married to: _____ Other: _____

Pharmacy Name: _____ **Street & City Location:** _____

Patient's Employer: _____ **Occupation:** _____

Work Phone: _____ Ext: _____ **Is it ok to contact you at work?** ☐ Yes ☐ No

Address: _____
Street & Apt # City State Zip

Emergency Contact: _____ **Relationship to Patient**: _____

Home Phone: _____ **Cell Phone:** _____ **Other Phone:** _____

How did you hear about Dr. Yee?

☐ Google ☐ Facebook ☐ Instagram ☐ Magazine ☐ Drive By ☐ Dr. Yee's Family/Friend

☐ Friend/Relative: _____ ☐ Doctor: _____ ☐ Other: _____

Areas of Interest: (circle all that apply)

Facial Procedures:		**Body Procedures:**		**Other:**		
Blepharoplasty	Face/Neck Lift	Abdominoplasty (Tummy Tuck)	Breast Reduction	Botox	Laser Hair Removal	CoolSculpting
Browlift	Laser Resurfacing	LipoSelection	Gynecomastia	Fillers	Tattoo Removal	EmsculptNeo
Earlobe Repair	Lip Augmentation	Brachioplasty	Labiaplasty	Skin Care	Lesions/Moles	Miradry
Facial Lipo	Otoplasty	Breast Augmentation		Facial Veins/Leg Veins	Skin Tightening	
Rhinoplasty	Septoplasty	Mastopexy (Breast lift)		IPL	Cellulite Reduction	

DR. SUZANNE YEE
Cosmetic & Laser Surgery Center
TRIPLE-BOARD CERTIFIED

Today's Date:_____

Height:_____ Weight:_____

Have you ever been diagnosed with any of the following conditions? Please give year:

Anemia or Bleeding Disorders		Heart Attack	
Anxiety/Depression		Hepatitis	
Arthritis		High Blood Pressure	
Asthma		HIV/AIDS	
Cancer		Kidney Disease	
High Cholesterol		Thyroid Disease	
Congestive Heart Failure		Sleep Apnea	
COPD/Emphysema		Fever Blisters	
Diabetes		Stroke	
Gout		Reflux/Constipation	
Other		Other	
Other		Other	
Other		Other	

Current Medications (Includes Prescriptions, Over the Counter, Skin Care & Herbal):

Name of Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list below:

Name of Medication	Type of Reaction
1.	
2.	
3.	

DR. SUZANNE YEE
Cosmetic & Laser Surgery Center
TRIPLE-BOARD CERTIFIED

Today's Date:_____

Have you or any member of your family, ever had difficulties with any medications, drugs or gases used for anesthesia?

☐ Yes ☐ No If yes, when, and where? _____

Do you have cocktails regularly, or consume regular amounts of alcoholic beverages? ☐ Yes ☐ No
If yes, how much? _____

Do you smoke, vape, or use Marijuana? ☐ Yes ☐ No If so, how much? _____ For how long? _____

Are you pregnant? ☐ Yes ☐ No How many pregnancies? _____ Births? _____ Breast Fed? ☐ Yes ☐ No

Have you ever been under psychiatric care? ☐ Yes ☐ No If yes, when? _____
Why?_____
_____

When was your last exam?

Test	Doctor	Approximate Date/Year
Physical Exam		
Eye Exam		
Chest X-Ray		
EKG		
Blood Work		

Past Surgical History:

Type of Procedure	Name of Surgeon	Approximate Date/Year

DR. SUZANNE YEE
Cosmetic & Laser Surgery Center
TRIPLE-BOARD CERTIFIED

Today's Date:_____

Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that I have received or read a copy of Dr. Suzanne Yee, Cosmetic & Laser Surgery Center's Notice of Privacy Practices. The privacy notice details how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Privacy Notice.

Red Flag Rule

I also understand a "Red Flag Rule" policy has been put in place to protect my information against identity theft. I hereby acknowledge that I received or ready a copy of the "Red Flag Rule" and understand the contents.

I request the following restriction(s) & reason(s) concerning the use of personal medical information.

Authorization of Release of Medical or Financial Information

Please list below any person(s) in addition to your referring physician and their practice or your insurance company that you are authorizing to receive or discuss medical records or financial information regarding your visits with our practice. Any persons listed below MUST PROVIDE THE LAST 4 DIGITS OF YOUR DRIVERS LICENSE NUMBER. I understand that if my personal identity is changed or compromised in any way, it is my responsibility to contact and inform Dr. Suzanne Yee's Cosmetic & Laser Surgery Center.

Name	Relationship to Patient

Further, I permit a copy of this acknowledgement with or without restrictions to be placed in my medical record.

__-__-__-__ **(please enter last 4 digits of DLN)**

Signed: _____ **Date: _____**

If not signed by the patient, please indicate relationship

- Parents or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____ **Date: _____**

For Office Use only:

Signed form received by: _____Date: _____

DR. SUZANNE YEE
Cosmetic & Laser Surgery Center
TRIPLE-BOARD CERTIFIED

Today's Date:_____

I received a copy or read "The Patient's Bill of Rights" from the office of Dr. Suzanne Yee.

I understand the office of Dr. Suzanne Yee does not accept advance directives (specific instructions, prepared in advance, that are intended to direct a person's medical care if he or she becomes unable to do so in the future).

I acknowledge I have received a copy of Dr. Yee's biographical synopsis.

I hereby release Dr. Suzanne Yee of filing Medicare for any services she administers. I understand it is my responsibility to pay for any services rendered.

I agree to the following as a patient of Dr. Suzanne Yee:

- To provide complete and accurate information to the best of my ability about my health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- To follow the treatment plan prescribed by Dr. Yee
- To provide a responsible adult to transport me from the facility and remain with me for 24 hours, if Dr. Yee deems it necessary.
- Inform Dr. Yee about any living will, medical power of attorney, or other directive that would affect my care.
- Accept personal financial responsibility for any charges.
- Be respectful of all the health care providers and staff, as well as other patients.

Signature: _____

Date: _____

Witness: _____