LAVINIA K. CHONG, M.D. 1401 Avocado Ave., Suite 803, Newport Beach, CA 92660, Phone (949) 644-1400 Fax (949) 644-5988

Today's Date: _____

PATIENT INFORMATION: _____
First Middle Initial Last

Address: _____
Street & Apt # City State Zip

Home Phone: _____ Email: _____

Cell Phone: _____ Permission to leave voicemail on: Home Phone: ☐Yes ☐No Cell: ☐Yes ☐No

Age: _____ Birthday: _____ SS#: _____ Permission to Text: ☐Yes ☐No

Gender assigned at birth: ☐Male ☐Female ☐Choose not to disclose Preferred form(s) of contact: ☐Call ☐Text ☐Email

PATIENT'S EMPLOYER: _____ Occupation: _____
Company Name

Work Phone: _____ Ext: _____ Is it okay to call you at work? ☐ Yes ☐ No

Address: _____
Street & Suite # City State Zip

HOW DID YOU HEAR ABOUT DR. CHONG? ☐ Web: _____
Name of Website

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

If you were referred by a specific person, may we thank them? ☐ Yes ☐ No

EMERGENCY CONTACT: _____ Relationship to Patient: _____

Cell Phone: _____ Home Phone: _____ Other: _____

AREAS OF INTEREST (mark all that apply)

FACE:

- ☐ Brow Lift
- ☐ Eyelid Lift (Blepharoplasty)
- ☐ Neck Lift (Cervicoplasty)
- ☐ Face Lift (Rhytidectomy)
- ☐ Fat Grafting
- ☐ Lip Lift
- ☐ Rhinoplasty (Nose Reshaping)
- ☐ Otoplasty (Ear Pinning)

BREAST:

- ☐ Gynecomastia (Men)
- ☐ Breast Reduction (Women)
- ☐ Breast Implant Removal (Explant)
- ☐ Breast Lift (Mastopexy)
- ☐ Fat Grafting
- ☐ Breast Augmentation (Implants)
- ☐ Breast Implant Exchange
- ☐ Breast Revision (Strattice/GalaForm)

BODY:

- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Arm Lift (Brachioplasty)
- ☐ Body Contouring (Lipo w/procedure)
- ☐ Bra Lift (Dorsal Rolls)
- ☐ Panniculectomy
- ☐ Puboplasty
- ☐ Umbilicoplasty
- ☐ Other: _____

Patient Signature: _____ Date: _____

Patient Name:	DOB:	Age:	Height:	Weight:

Purpose/Goal of today's visit:

_____

_____

Have you consulted with other doctors regarding this concern? ☐ Yes ☐ No (*If yes, please list the doctor's name)*:

_____

Have you had any previous surgeries to address this concern? ☐ Yes ☐ No (*If yes, when)*:

_____

MEDICAL HISTORY

Do you have any allergies to food and/or medications? ☐ Yes ☐ No

(*Please check box below indicating Allergy or Reaction to what type of food or medication, and please provide details on your experience*):

Medical Allergy	Adverse Reaction	Name of Medication or type of food	Please describe in detail the nature of the allergy and/or the type of reaction, and on what occasion(s) did the reaction occur:

List any medications you are currently taking (*Include OTC medications, supplements, vitamins, etc.*):

Medication	Strength	# per day	Medication	Strength	# per day
1)			4)		
2)			5)		
3)			6)		

List any prior surgeries you have undergone in the past:

Surgery	Date of Surgery

Have you ever experienced any complications related to anesthesia? ☐ Yes ☐ No (*If yes, please specify below*):

☐Post-op nausea/vomiting ☐Intra-Op Recall ☐Slow to wake ☐Malignant Hyperthermia ☐Other

Have you ever experienced complications related to a previous surgery? ☐ Yes ☐ No (*If yes, please specify)*:

_____

Are you currently, or have you in the past, received psychiatric assistance? ☐ Yes ☐ No

(*If yes, please list name and address of psychiatrist or psychologist*):

_____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Patient Name: _____ Date: _____

Do you currently, or have you in the past, smoked? (*Account for cigarettes, vapes, and marijuana*)

☐ Yes ☐ No _____ (*Amount/Day*) For how long? _____ (*Years*)

Have you had any adverse reactions to the following? (*Please circle any of the following that apply*)

☐ Yes ☐ No Local Anesthetics (Lidocaine, Epinephrine)

☐ Yes ☐ No Skin Disinfectants (Betadine, Chlorohexidine)

☐ Yes ☐ No Adhesive Tape

☐ Yes ☐ No Pain Medications (*Please specify):* _____

☐ Yes ☐ No Antibiotics (*Please specify):* _____

Do you currently have, or have you had in the past, a history of any of the following? (*Check all that apply*)

Cardiovascular:

- ☐ Abnormal Heart Rhythm
- ☐ Anemia/Bleeding Disorder
- ☐ Blood Clot
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Irregular EKG
- ☐ Low Blood Pressure
- ☐ Problem with Circulation
- ☐ Stroke
- ☐ Use Blood Thinners: _____

Respiratory:

- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis –
  Use of steroids? Yes / No
  Use of nonsteroidals? Yes / No
- ☐ COVID-19 Vaccinated? Yes / No
  If yes, manufacturer: _____
- ☐ Emphysema
- ☐ Require CPAP/BIPAP for Sleep
- ☐ Pneumonia
- ☐ Shortness of Breath At Rest
- ☐ Sleep Apnea
- ☐ Unproductive Cough

Diabetes:

- ☐ Oral Hypoglycemia
- ☐ Type I
- ☐ Type II
- ☐ Use Insulin
- ☐ Use Insulin Pump
- ☐ Well Controlled

Neurological Disorder:

- ☐ Chronic Neck/Back Pain
- ☐ Multiple Sclerosis
- ☐ Nerve/Spinal Cord Injury
- ☐ Neuropathy
- ☐ Seizures
- ☐ Shingles
- ☐ Stroke

Gastro-Intestinal/Genitourinary:

- ☐ GERD/Acid Reflux
- ☐ Frequent Urinary Tract Infections
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Irregular Bowel Movements

Gyn/General Surgery:

- ☐ History of Pregnancy
  Number of Births ____
  Breastfed: Y / N
- ☐ History of Procedure:
- ☐ Hernia
- ☐ C-Section
- ☐ Laparoscopy
- ☐ Cholecystectomy
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Date of Last Mammogram
  _____ / _____ / _____
- ☐ Date of Last Menstrual Period
  _____ / _____ / _____

Miscellaneous:

- ☐ ADHD
- ☐ Anxiety
- ☐ Autoimmune Disease
- ☐ Cancer (Personal History)
- ☐ Cancer (Family History)
- ☐ Cold Sores
- ☐ Depression
- ☐ Dry Eyes
- ☐ Environmental Allergies
- ☐ Scars (Keloid/Hypertrophic)
- ☐ Lasix
- ☐ Problems with Wound Healing
- ☐ Skin Disorders
- ☐ Other:
  _____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

OFFICE POLICIES FOR LAVINIA K. CHONG, M.D.

1. New Patient Packet must be completed before seeing Dr. Chong.
2. A Photo I.D. is required for all patients.
3. We accept the following forms of payment:
   cash, check, VISA, MasterCard, Discover, American Express, Care Credit, and Alphaeon.
4. Charges for laboratory, pathology and lab services are separate and additional. Patients are responsible for these items.
5. A deposit of 20% is required to reserve surgery dates.
6. Returned checks have a $35.00 fee for insufficient funds. For credit cards, there will be a charge (of up to 5% of the original charge) for crediting back funds.
7. The adult accompanying a minor and/or the parents (or guardians) are responsible for full payment.
8. If you arrive 30 minutes past your scheduled appointment you may be asked to reschedule.
9. Copies of patient records are available upon request by the patient. A $50 printing fee and any applicable delivery fees may be applied. Color copy fees for photos will be charged by the page. Please allow 72 hours to process any records requests.
10. This office strictly prohibits electronic recording or videotaping of any kind in consideration of the privacy and confidentiality of the physician-patient relationship.

PRIVACY PRACTICES ACKNOWLEDGEMENT AGREEMENT

ACKNOWLEDGEMENT FORM

A copy of the Notice of Privacy Practices can be found online and in-office. By signing, I acknowledge that I have received the Notice of Privacy Practices and/or have been provided an opportunity to read the Agreement thoroughly. If I have any questions, I can contact the office staff by calling (949) 644-1400.

Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____

PLEASE READ CAREFULLY

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____.

"Physician" shall be understood to mean **Lavinia K. Chong, M.D.**

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the ***American Board of Plastic Surgery.***

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the ***American Board of Plastic Surgery*** and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and Patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____	_____
Physician Signature	Patient Signature
_____	_____
Effective from Date of Treatment	Date of Signature

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Lavinia K. Chong, M.D. (collectively labeled "*Physician"*) agree to provide treatment to:_____("Patient"). The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are almost always forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Even after recent Congressional attempts to tighten this restriction, however, there are still loopholes that some medical practices can use to profit from marketing activities. For example, there are exceptions for drugs currently prescribed to the patient and for recommending items or services covered by the patient's health plan. More importantly, there is no prohibition against a physician putting his patient on the spot and asking for permission to allow third parties access to information to market to patients, which could authorize essentially unlimited unwanted marketing information. Even to the extent still allowed, Physician agrees not allow others access to use Patient's medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's permission for a third party to market directly to Patient.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Importantly, Physician agrees to abide by a Code of Internet Ethics. What that means: Physician agrees to enforce no rights enabled by the assignment if Patient's commentary conforms to typical Internet Rating Sites' Terms of Use (such as Google Maps –see http://www.google.com/help/terms_maps_earth.html). Such terms include, as examples, no obscenity, no personal attacks, and the like. To be clear, constructive commentary, even if negative, helps us build a better practice. The Code of Internet Ethics encourages posting of all constructive commentary, good, neutral, and even, negative.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

_____ _____

Print Patient's Name Patient's Signature

_____

Date

_____ _____

Physician's Name Physician's Signature

_____

Date

Version 2.0.6T

PATIENT'S RIGHTS & RESPONSIBLITIES

PATIENTS' RIGHTS

- Exercise these rights without regard to sex, cultural, economic, educational, religious background, or the source of payment for care.
- Patients are given equitable, unbiased, considerate, and respectful care.
- Patients are provided appropriate privacy regarding medical records and during interviews, examinations, treatment, and consultation. Medical information will not be released without patient's written consent.
- Patients are given the opportunity to participate in decisions involving their health care.
- Patients are in receipt of sufficient information in advance if feasible, to allow a patient to give informed consent or to refuse any proposed treatment or procedure.
- Patients are provided, to the degree known, complete information concerning their diagnosis, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Patient should have knowledge of the name of the physician primarily responsible for care, and the names and roles of any other physicians involved in their care.
- Patients, prior to treatment, are informed of their financial responsibility and are provided with a receipt and explanation of their bill, regardless of source of payment.
- Patients have ability to have their complaints addressed, and to receive an appropriate response.
- Facility should provide information to patients and staff concerning:
    - Services available at the facility
    - Provision for after-hour and emergency care
    - Fees for services and payment policies
    - Methods for expressing grievances and suggestion to the facility

PATIENTS' RESPONSIBLITES

- Participate in, and follow agreed-upon plan of care.
- Fully participate in decisions involving their own health care.
- Cooperate with physician and ask questions if not understanding instruction or information.
- Provide physician with complete and accurate history about illnesses, hospitalizations, medications, and other matters related to your health.
- Notify facility if there is any problem or dissatisfaction with care or services.
- Treat personnel with respect, consideration, and dignity.
- Give timely notice when canceling an appointment.

Patient Signature: _____ Date: _____