PATIENT INFORMATION FORM

Welcome to Dr. Shibayama's office! We appreciate the opportunity to meet with you to discuss healthy skin and your skin care needs. Please take a minute to fill out basic information and review our cosmetic practice policies.

Name _____ DOB _____

E-mail _____ Appointment Confirmation Phone # _____

Address _____ City _____ St ____ Zip _____

Home Phone_____Work Phone_____Cell Phone_____

Emergency Contact _____ Emergency Contact Phone # _____

REFERRAL INFORMATION

Primary Care Physician _____ Referred By _____

How did you learn about us?

☐ Friends ☐ Physician ☐ Yellow Pages ☐ Web Page/Internet ☐ Seminar

HOURS

Our normal office telephone hours are 8:30 am to 4:30 pm Monday through Friday. Our receptionist is instructed to handle all incoming calls. After hours emergencies should be directed to our main number: 530.886.6700.

POLICIES

- Consultations are free of charge.
- We are unable to estimate the cost of procedures until the physician has completed an evaluation of your specific needs.
- There is a $150 fee for all scheduled procedures that are not kept, unless at least 24 hours advance notice of cancellation has been provided.
- There is a $25 fee for each cancelled check.
- For your convenience, we accept VISA, MasterCard, cash and personal checks.

I understand all procedures are considered to be cosmetic (and therefore not covered by insurance) and I agree to pay for the procedure(s) in full at the time of service.

Signature _____ Date:_____

NANCY SHIBAYAMA, M.D., INC.

BOARD CERTIFIED INTERNAL MEDICINE

11795 Education Street, Suite 209, Auburn, CA 95602
TEL (530) 886-6700 ● FAX (530) 886-6701

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment, or healthcare operations. You have a right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices and the Patient has the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures shall then cease.
- The practice may condition delivery of treatment upon execution of this consent.

Do we have your permission to:

- Leave a message on your answering machine or cell phone. Y N
- Leave a message at your work number. Y N
- Discuss you medical conditions with any member of your household Y N

Patient Signature _____ Date _____

Patient Name _____

COSMETIC MEDICAL HISTORY FORM

Name: _____ Phone: _____

Allergies: _____

Medications (including vitamins, supplements): _____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Have you ever had or been treated for any of the following? (Check all that apply)

☐ Artificial heart valves	☐ Difficult wound healing	☐ Kidney disease
☐ Artificial joints	☐ Easy bruising/bleeding	☐ Liver disease
☐ Asthma	☐ Eczema	☐ Neuromuscular disease
☐ Autoimmune disease	☐ Fever blisters	☐ Seizures
☐ Cancer	☐ Glaucoma	☐ Skin cancer
☐ Cold sores	☐ Heart disease	☐ TB or Lung disease
☐ Blood clots/Phlebitis	☐ High blood pressure	☐ Thyroid disease
☐ Depression	☐ Hives	☐ Ulcers
☐ Diabetes	☐ Keloids/Overgrown scars	☐ Other

	Yes	No
2. Are you or could you be pregnant?	☐	☐
3. Do you have a history of Herpes I or II in the area to be treated?	☐	☐
4. Do you have a history of keloid scarring?	☐	☐
5. Have you taken Accutane in the last 6 months?	☐	☐
6. Are you currently taking retinoids (Retin-A, Renova)?	☐	☐
7. Do you have any permanent make-up, implants or tattoos?	☐	☐
8. Have you had any unprotected sun exposure, used tanning creams or tanning beds in the last 4-6 weeks?	☐	☐

PLEASE INDICATE THE SERVICES THAT INTEREST YOU (CHECK ALL THAT APPLY):

☐ Acne Treatment	☐ Laser hair reduction	☐ Scars and Wrinkles
☐ Blood vessels/Rosacea	☐ Laser Resurfacing	☐ Skin care products
☐ Botox	☐ Leg Veins/Sclerotherapy	☐ Skin rejuvenation
☐ Collagen/Fillers	☐ Pigment/Sunspots	☐ Skin tightening

Signature _____ Date _____