



Sam M. Sukkar, M.D., F.A.C.S.
1616 Clear Lake City Blvd, Suite 102
Houston TX 77062
281-990-8487 phone /281-204-8018fax

LAST NAME _____ FIRST NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ ALTERNATE CONTACT # _____

DATE OF BIRTH _____ AGE _____ SEX _____ MARITAL _____

EMAIL _____

PATIENT SS# _____ REFERRED BY _____

EMERGENCY CONTACT PERSON/ RELATIONSHIP: _____

EMERGENCY CONTACT NUMBER: _____

YOUR EMPLOYER _____

EMPLOYERS'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER'S PHONE # _____ EXT _____

DATE OF INJURY OR ONSET OF MEDICAL CONDITION: _____

WORK RELATED? _____ AUTOMOBILE ACCIDENT? _____

INSURANCE INFORMATION (RECONSTRUCTIVE PATIENTS ONLY)
(A COPY OF YOUR INSURANCE CARD WILL BE REQUESTED)

MEDICARE # _____

(PRIMARY)
INSURANCE#1 _____

ADDRESS _____

POLICY HOLDER'S NAME _____ RELATIONSHIP _____

ID # _____ GROUP # _____

(SECONDARY)
INSURANCE#2 _____

ADDRESS _____

POLICY HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____

I authorize payment directly to the Physician of the Surgical/Medical Benefits, if any, otherwise payable to me for his services as described, realizing I am responsible to pay non-covered services and I authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE _____ DATE _____



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PHOTO CONSENT

For documentation purposes, Dr. Sukkar requires before and after photographs for my confidential medical records. I have been informed of this policy.

Patient Name: _____ (print)

Patient Signature: _____

Date: _____

I also grant permission for Dr. Sukkar the use of my patient photographs for the following types of media including but not limited to the following:

- PRINT
- VISUAL
- ELECTRONIC
- INTERNET

Patient Signature: _____

Date: _____



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GENERAL INTAKE INFORMATION

DATE_____

NAME_____ AGE_____

LAST FIRST MIDDLE

Referring Physician_____ Phone_____

CHIEF COMPLAINT/REASON FOR VISIT_____

PRESENT ILLNESS_____

PAST HISTORY

1. SERIOUS ILLNESS_____

2. OPERATIONS_____

3. OTHER HOSPITALIZATIONS_____

4. PRESENT MEDICATIONS_____

MEDICATIONS AFFECTING BLEEDING: please circle ASA VITAMIN E IBUPROFEN

BLEEDING DISORDERS? Y N

VEIN DISORDERS? Y N

DIETARY/HERBAL SUPPLEMENTS_____

5. ALLERGIES_____

LATEX ALLERGY? Y N

FAMILY HISTORY_____



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PERSONAL HISTORY QUESTIONNAIRE

DATE _____

NAME _____ DOB _____ AGE _____
 LAST FIRST MIDDLE

HEIGHT _____ WEIGHT _____ SEX: M F MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

DATE OF LAST PHYSICAL EXAM _____ PHYSICIAN _____

PAST MEDICAL HISTORY: Do you have or have you had? (If yes, give date of occurrence.)

AIDS OR HIV	N	Y _____	SCHLERODERMA	N	Y _____
THYROID	N	Y _____	ASTHMA	N	Y _____
HEART	N	Y _____	LUPUS	N	Y _____
KIDNEYS	N	Y _____	CANCER	N	Y _____
GALLBLADDER	N	Y _____	ARTHRITIS	N	Y _____
STOMACH	N	Y _____	BLOOD PRESSURE	N	Y _____
HEPATITIS	N	Y _____	LUNGS	N	Y _____
BLEEDING TENDENCIES	N	Y _____	NERVOUS PROB	N	Y _____
FIBROMYALGIA	N	Y _____	BLEEDING PROBS	N	Y _____

Do you regularly smoke? Y N How much per day? _____

Do you regularly drink over 3 cups of coffee per day? Y N

Do you regularly drink alcohol or beer? Y N How much per week? _____

MEDICATIONS: Are you presently taking any of the following? (Circle)

Aspirin/Anacin	Cough Medicine	Antibiotics	Phenobarbital
Bufferin	Dilantin	Thyroid Pills	Blood Pressure Pills
Motrin	Blood Thinners	Iron	Hormones
Ibuprofen	Insulin/diabetic pills	Digitalis	Sleeping Pills
Birth Control Pills	Arthritis medication	Cortisone	Water Pills

Other Medication not listed _____

Aspirin and aspirin type products can cause excessive bleeding during surgery.

WOMEN ONLY

Is there a chance you may be pregnant? Y N Regular Menses? Y N Date of last period _____

Any complications with pregnancies? _____

How many pregnancies? _____ How many children? _____ Did you breastfeed? Y N How many? _____

Date of last mammogram _____ Normal or Abnormal Specify _____

Breast Cancer L R Date _____ Mastectomy _____ Date _____

Breast Biopsy L R Date _____ Oncologist _____

Surgeon for Breast Biopsy _____ Phone # _____



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PRIVACY PRACTICES

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Office Manager
Sam M. Sukkar, M.D. and Sukkar Aesthetic Plastic Surgery
1616 Clear Lake City Boulevard, Suite 102
Houston, Texas 77062
(281) 990-8487

Effective Date

This Notice is effective on or after 4/13/2003

Sam M. Sukkar, M.D. and Sukkar Aesthetic Plastic Surgery Duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the **Receptionist Associate** or **Office Manager**. Your request will be reviewed and generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Sam M. Sukkar, M.D.
The Clinic for Plastic Surgery, P.A.
1616 Clear Lake City Boulevard, Suite 102
Houston, Texas 77062

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

The Clinic for Plastic Surgery, P.A. and Sam M. Sukkar, M.D. reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for **The Clinic for Plastic Surgery, P.A. and Sam M. Sukkar, M.D.**

PATIENT NAME (PRINT OR TYPE)

SIGNATURE OF PATIENT

Date

SIGNATURE OF PATIENT REPRESENTATIVE
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient