



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 _____

Mailing Address (If Different) _____

Home Phone _____ Cellular Phone _____

Date of Birth _____ Age _____ Sex _____ Marital _____

SS# _____ Referred by _____

Email address _____

Drivers License # _____ Exp _____

Valid ID required for a copy

Emergency Contact/ Relationship: _____ / _____

Emergency Contact Phone #: _____

Employed by: _____

Employer's Address: _____ City _____ State _____ Zip _____

Work Phone# _____ EXT _____

*I authorize Sam M. Sukkar, MD and/or office staff to leave messages for me on:

Home#: Y or N Cell#: Y or N Work#: Y or N (please circle)

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

MEDICARE # _____

Primary Insurance Carrier: _____

Address: _____

Insurance Company Phone #: _____

Policy Holder: _____ S.S.# _____

Policy # _____ Group# _____

DOB of Policy Holder _____ Relationship to Patient: _____

** PLEASE PRESENT COPY OF SECONDARY/SUPPLEMENTAL INSURANCE CARD, IF APPLICABLE.

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 _____



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

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: _____

*** DUE TO THE SENSITIVE NATURE OF OUR BUSINESS, CHILDREN UNDER THE AGE OF 16 ARE NOT ALLOWED***

I am aware of this policy and understand that my appointment may be rescheduled or cancelled if not compliant.

Patient Signature

Date



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

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 _____



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

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 # _____



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
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



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

Are you interested in receiving more information on any of the following?

Please circle and describe:

Dermal Fillers: Yes / No

Concerns to discuss : _____

Botox: Yes / No

Concerns to discuss: _____

Sclerotherapy: Yes / No

Concerns to discuss: _____

Laser Tattoo Removal: Yes / No

Concerns to discuss: _____

MicroLaser Facial Peel: Yes / No

Concerns to discuss: _____

Mild Facial Peel: Yes / No

Concerns to discuss: _____

Skin Care: Yes / No

Concerns to discuss: _____