The Virginia Institute for Surgical Arts
25055 Riding Plaza, Suite 140
Chantilly, VA 20152
Phone: 703-327-8500
drvfacialplastics.com

THE VIRGINIA INSTITUTE
FOR SURGICAL ARTS

PATIENT COSMETIC INFORMATION FORM

Welcome to the Practice! The Virginia Institute for Surgical Arts provides advanced and natural-looking facial aesthetic and reconstructive surgery. Combining the latest in precision technology with the highest standards of surgical craftsmanship, we indulge our patients with bespoke premium care and exalted experiences. Innovative specialized skin and laser treatments augment surgical advancement to refresh and revitalize. Our surgical approach appreciates the beauty and simplicity of nature adorned to balanced proportions that refine and elevate.

Dr. Trang Vo-Nguyen (Dr. V) is a facial plastic surgeon at The Virginia Institute for Surgical Arts. She dedicates her practice to the artistry of sculpting the face through a complement of precise surgical and understated interpretations – to restore and enhance. Following rigorous peer review, Dr. Vo-Nguyen has been elected to become a rare Diplomate certified by the prestigious and exclusive American Board of Facial Plastic and Reconstructive Surgery. As an architect for facial elegance, Dr. V focuses her expertise on indulgent rejuvenation of the aging face, and its reformation through reconstructive imperatives. Dr. V remains vigilant in her oath to oblige the needs of her patients through compassionate understanding of unique concerns and aspirations, and to achieve natural and enduring improvements.

Patient Name: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

DOB & Age: _____ Race: _____

SSN: _____ Gender: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

How did you hear about our clinic?

☐ Patient Referral: _____
☐ Friend: _____
☐ Google ☐ Dr. Referral: _____
☐ Other: _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐Parent/Guardian ☐Other _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

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Section I: Surgery and Anesthesia History

1. Have you ever had surgery?(include plastic surgery) ☐ No ☐ Yes, please describe:

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Weight:
Height:

	Have you or do you still have:	No	Yes	Description
2.	Asthma	☐	☐	
3.	Emphysema	☐	☐	
4.	High Blood Pressure	☐	☐	
5.	Heart Trouble	☐	☐	
	Have you ever seen a cardiologist?	☐	☐	If yes, Physician Name:
	Date of last EKG?			
6.	Hepatitis or Liver Trouble	☐	☐	
7.	Kidney Trouble	☐	☐	
8.	Diabetes	☐	☐	
9.	Epilepsy or Seizures	☐	☐	
10.	Stroke	☐	☐	
11.	Problem Scarring - thickening of scars or keloids following injury or surgery?	☐	☐	
12.	Do you bruise easily or bleed excessively?	☐	☐	
13.	Have you ever had a blood clot in your legs or lungs (DVT or pulmonary embolism)?	☐	☐	
14.	Have you ever had herpes simplex (cold sores)?	☐	☐	
15.	Have you ever had any weakness of the face or drooping of any part of the face?	☐	☐	
16.	Have you ever had "dry eyes" or eye infections?	☐	☐	
17.	Have you ever had fainting spells, black outs, TIA's or strokes?	☐	☐	

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		No	Yes	Description
18.	Do you have any neck problems, or arthritis?	☐	☐	
19.	Do you have problems with motion sickness or nausea after anesthesia?	☐	☐	
20.	Have you ever received a blood transfusion?	☐	☐	
21.	Do you have any infectious diseases?	☐	☐	

Do you have: (circle) Chipped teeth/Caps/Dentures/Contact Lenses/Metal Body Piercings/None

22. Others Not Listed: _____

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____
3. Do you have children? ☐ No ☐ Yes, how many? _____

Section V: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

_____

_____

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

_____

Section VII: Skin Care

		No	Yes	Description
1.	Current or past Accutane use?	☐	☐	
2.	Current or past Retin-A use?	☐	☐	
3.	Are you allergic to any products?	☐	☐	
4.	Do you have any metal implants in your body?	☐	☐	

Please describe your current skin care regiment and products used: _____

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		No	Yes	Description
5.	Have you seen a physician for your skin? If YES, please explain for what reason and when?	☐	☐	
8.	Do you have any metal implants in your body?	☐	☐	

Please describe your current skin care regiment and products used: _____

Section VIII: Past Procedures

		No	Yes	Description/ Date
1.	Chemical Peel (Type of peel)?	☐	☐	
2.	Facial Surgery?	☐	☐	
3.	Laser Resurfacing?	☐	☐	
4.	Laser Hair Removal?	☐	☐	
5.	BOTOX™/DYSPORT™ ?	☐	☐	
6.	RESTYLANE™/JUVEOERM™?	☐	☐	
7.	Have you had any micropigmentation?	☐	☐	

If YES, where on your face and when did you have the procedure?

Section IX: Your Pigmentation, Acne + Sensitivity

		No	Yes	Description/ Date
1.	Do you regularly use a sunscreen?	☐	☐	
2.	Will you diligently use a sunscreen daily?	☐	☐	
3.	Do you use tanning beds?	☐	☐	
4.	Does your skin generally feel oily?	☐	☐	
5.	Do you have a history of acne breakout?	☐	☐	
6.	Do you have facial wrinkles? If yes, where?	☐	☐	
7.	Does your skin feel tight/ dry?	☐	☐	
8.	Is your skin thin and appear fragile?	☐	☐	
9.	Do you heal well from a cut or a burn?	☐	☐	

If NO, please explain:

☐ Hyperpigmentation ☐ Hypopigmentation
☐ Hypertrophic scar ☐ Other

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10. What kind of breakouts do you/have you had? (check one) ☐ Pimples ☐ Blackheads ☐ Whiteheads ☐ Enlarged Pores ☐ Acne Scars ☐ Other
11. How do you react to sun exposure? ☐ Always Burn ☐ Usually Burn ☐ Sometimes Burn ☐ Rarely Burn ☐ Almost Never Burn ☐ Never Burn
12. How much time do you spend outdoors/ week? ☐ Less than 5 hours ☐ More than 5 hours ☐ 10+ hours
13. Daily water intake: ☐ None ☐ Low (1-2 glasses) ☐ Average (3-4 glasses) ☐ High (over 8 glasses)
14. Daily caffeine intake: ☐ None ☐ Low (1-2 cups) ☐ Average (3-4 cups) ☐ High (over 8 cups)
15. How would you most like to improve your skin?

_____

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

I _____, hereby consent to the use or disclosure of my protected health information by the practice of Trang Vo-Nguyen, M.D., hereinafter referred to as ("Practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Dr. Vo-Nguyen may be conditioned upon my consent as evidenced by my signature on this document.

I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to these restrictions, which I may request. However, if the practice agrees to the restrictions that I request, the restriction is binding on the practice and Dr. Vo-Nguyen.

I have the right to revoke this consent, at any time, in writing, except to the extent that Dr. Vo-Nguyen or the practice has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by Dr. Vo-Nguyen, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have a right to review the practice's Notice of Privacy Practices, which is available to me by request at any time, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation. This Notice of Privacy Practices also describes my rights and practice's duties with respect to my protected health information. The Notice of Privacy Practices for the practice is also provided at 25055 Riding Plaza, Suite 140, Chantilly, VA 20152.

As provided in our notice, the terms of our notice may change. If changes are made, I may obtain a revised Notice of Privacy Practices by calling your office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

"To the best of my knowledge, the information I have provided regarding my medical history, allergies and smoking history is accurate, complete and honest. I understand failure to completely disclose this information may be detrimental to my condition and treatment and I accept full responsibility for any omissions."

I understand that photography is a necessary part of planning and evaluating cosmetic surgery. I authorize the taking of photographs at the direction of Dr. Vo-Nguyen and under such conditions as may be approved by Dr. Vo-Nguyen. These photographs will be used solely for documentation and educational purposes and will be kept confidential.

A copy of this authorization shall be considered as valid as the original.

Patient Signature: _____ Date: _____

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CONSENT TO COMMUNICATE

Patient Name: _____

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email			☐	-
☐ Email Appointment Reminders				
☐ Email Medical Information				
☐ Email Office Specials				
☐ Send Regular Mail			☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message - if ok, please list cell carrier (e.g., AT&T):			☐	-
☐ Text Appointment Reminders				
☐ Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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HIPAA INFORMATION AND CONSENT FORM

Patient Name: _____ DOB: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the
patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____