Anal Aesthetics
& Wellness

**BETH MOORE, MD, FACS, FASCRS**
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**90211 Phone: (310) 854-3580 Fax (310) 659-5830**

## PATIENT INFORMATION SHEET

**Please Print** the information on this form carefully. We need it to prepare our records to take care of government & legal requirements. Thank you for your cooperation.

NAME ______________________ BIRTH DATE __________ AGE __________

SEX: M F HEIGHT __________ WEIGHT __________

HOME ADDRESS ______________________ CITY ______________ STATE ________ ZIP __________

HOME PHONE ______________ CELL ______________

EMAIL ______________________

PHARMACY NAME ______________ PHONE NUMBER ______________ ZIP CODE __________

OCCUPATION ______________________

REFERRED BY ______________

EMERGENCY CONTACT ______________________ PHONE ______________

## COMPREHENSIVE PATIENT HISTORY

**Reason for Visit:** ______________________

**ALLERGIES:** Please list any allergies to medications, tape or latex and describe the reaction that you experience.

| **Allergy** | **Reaction** |
|---|---|
| 1. ______________ | ______________ |
| 2. ______________ | ______________ |
| 3. ______________ | ______________ |

**MEDICATIONS:** Please list all medications you are taking.

1. ______________ 3. ______________

2. ______________ 4. ______________

**SUPPLEMENTS:** List all supplements, vitamins, and herbs you are taking including Vitamin E, Gingko Biloba, Ginseng, and Fish Oil.

______________________________________________

______________________________________________

**MEDICAL HISTORY:** Please indicate if you have or had any of the following, followed by a brief explanation if necessary.

| | | | Comments |
|---|---|---|---|
| Heart Disease | ☐ Yes | ☐ No | ______ |
| Lung Disease | ☐ Yes | ☐ No | ______ |
| Liver Disease/Hepatitis | ☐ Yes | ☐ No | ______ |
| Kidney Disease | ☐ Yes | ☐ No | ______ |
| Diabetes | ☐ Yes | ☐ No | ______ |
| Cancer | ☐ Yes | ☐ No | ______ |
| HIV | ☐ Yes | ☐ No | ______ |
| Seizure Disorder | ☐ Yes | ☐ No | ______ |
| Hypertension | ☐ Yes | ☐ No | ______ |
| Bleeding Disorder/Tendency | ☐ Yes | ☐ No | ______ |
| Orthopedic Prosthesis/Implant | ☐ Yes | ☐ No | ______ |
| Thyroid Disease | ☐ Yes | ☐ No | ______ |
| Sleep Apnea | ☐ Yes | ☐ No | ______ |
| Sexually Transmitted Disease | ☐ Yes | ☐ No | ______ |
| Genital Warts | ☐ Yes | ☐ No | ______ |
| HSV I (oral/cold sore) | ☐ Yes | ☐ No | ______ |
| HSV II (genital/anal) | ☐ Yes | ☐ No | ______ |
| Pacemaker | ☐ Yes | ☐ No | ______ |
| internal defibrillator electronic | ☐ Yes | ☐ No | ______ |
| Implant | ☐ Yes | ☐ No | ______ |
| Skin Cancer | ☐ Yes | ☐ No | ______ |
| Pre-Malignant Moles | ☐ Yes | ☐ No | ______ |
| Psoriasis | ☐ Yes | ☐ No | ______ |
| Eczema | ☐ Yes | ☐ No | ______ |
| Any Rash | ☐ Yes | ☐ No | ______ |
| Keloid Scarring | ☐ Yes | ☐ No | ______ |
| Dry or Fragile skin | ☐ Yes | ☐ No | ______ |
| Abnormal Wound Healing | ☐ Yes | ☐ No | ______ |
| Other | ☐ Yes | ☐ No | ______ |

**SURGICAL HISTORY**: Please list any operations that you have and when they were done.

______________________ ______________________

______________________ ______________________

______________________ ______________________

**FAMILY HISTORY**: Please list any family history of colon, breast, uterine, ovarian, or stomach cancer, colon polyps, Crohn's disease or ulcerative colitis. Please indicate the relationship of each family member listed (mother, father, brother, sister, etc.) and the age of onset.

______________________ ______________________

______________________ ______________________

______________________ ______________________

**COLON AND RECTAL HISTORY**

Have you ever had a colonoscopy? ☐ Yes ☐ No If so, when? ______________________

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## Notice of Privacy Practices

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1966 (HIPAA).

## Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

## Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

## Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our Privacy Officer.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer.

I hereby acknowledge that I have been presented with a copy of Dr. Beth A. Moore Notice of Privacy Practices.

Patient Signature: ______________________________________

Today's Date: ___________________________________________

Print Name of Patient: ___________________________________