DISTRICT PLASTIC SURGERY
PRAFUL RAMINENI, MD

2440 M Street NW, Suite 201
Washington, DC 20037
P 202-742-3999
F 202-742-3995
www.districtplasticsurgery.com

Patient Information

Legal Name: Preferred Name:		DOB:	Today's Date:
Address:			
City:		State:	Zip:
Home Phone:		Cell Phone:	
Email Address:			
Social Security Number:		Marital Status:	
Pronouns:		Work Phone:	
Who is your Primary Care Physician?			
How did you hear about Dr. Praful Ramineni?			
EMERGENCY CONTACT			
Name:		Relationship:	
Address:			
City:		State:	Zip:
Home Phone:		Cell Phone:	
Insurance Information			
Insurance Company:	Effective date/end date (if known)		
Policy #:	Group #:		
Insurance Phone number (back of card):			
Primary Policy Holder – (self/spouse/parent)			
Primary Policy Holder Name, Date of Birth (if not primary):			
Secondary Insurance Company (if any)			
Secondary Insurance Phone #:			
Policy #	Group Number:		
Secondary Insurance - Primary Policy Holder Name, Date of Birth:			

PROCEDURES OF INTEREST

BODY	**BREAST**	**FACE**	**IN OFFICE**
O Arm Lift	O Breast Augmentation	O Brow Lift	O Botox
O Body Contouring after major weight loss	O Breast Implant Explant	O Buccal Fat Removal	O Fillers
O Body Lift	O Breast Implant Revision	O Chin Enlargement	O Latisse
O Buttock Lift	O Breast Lift w/Augmentation	O Ear Pinning	O Mohs
O Buttock Enlargement (BBL)	O Breast Lift	O Eyelid Lift	O Mole/ Lipoma Removal
O Correction of tummy tuck or liposuction	O Breast Reduction	O Face Feminization	O Scar /Keloid Revision
O Hernia Repair	O Correction of inverted nipples	O Face Lift	O Other:
O Labiaplasty	O FTM Top Surgery	O Neck Lift	
O Liposuction	O FTX Top Surgery	O Submental Liposuction	
O Orchiectomy	O Gynecomastia	O Other:	
O Panniculectomy	O MTF Top Surgery		
O Thigh Lift	O MTX Top Surgery		
O Tummy Tuck	O Nipple Reduction		
O Vaginoplasty	O Other:		
O Other			

DISTRICT PLASTIC SURGERY
PRAFUL RAMINENI, MD

2440 M Street NW, Suite 201
Washington, DC 20037
P 202-742-3999
F 202-742-3995
www.districtplasticsurgery.com

SURGERY & ANESTHESIA HISTORY

DISTRICT PLASTIC SURGERY
PRAFUL RAMINENI, MD

2440 M Street NW, Suite 201
Washington, DC 20037
P 202-742-3999
F 202-742-3995
www.districtplasticsurgery.com

Have you ever had surgery? O No O Yes
If yes, please describe:
Do you have a blood relative who has had anesthesia complications of any kind? O No O Yes
If yes, please describe:

MEDICAL HISTORY

Are you pregnant? O No O Yes	If yes, due date:
Height:	Weight:

Do you have a history of the following:	Yes	No	Description:
Asthma/ Chronic Cough			
Emphysema/Shortness of Breath			
High Blood Pressure			
Heart Trouble/Chest Pain			
Hepatitis or Liver Trouble			
Kidney Trouble/ Urinary Problems			
Diabetes			
Epilepsy or Seizures			
Stroke			
Problem Scarring			
Blood Clots/Multiple miscarriages			
Bleeding Problems			
Psychiatric Care			
Others Not Listed			

MEDICATIONS

Are you taking any of the following:	Yes	No	Description:
Blood pressure medication			
Antidepressants			
Tranquilizers or Sedatives			
Blood thinners			
Steroids / **H**ormone **R**eplacement **T**herapy			
Diabetes medication			
Seizures			
Heart medication			
Aspirin or aspirin-containing meds			
Ketoprofen (Alleve)			
Ibuprofen (Motrin, Advil)			
Vitamin E or Fish Oil			
Other			

Please list the medications you are **currently** taking:
Medications (continued)

DISTRICT PLASTIC SURGERY
PRAFUL RAMINENI, MD

2440 M Street NW, Suite 201
Washington, DC 20037
P 202-742-3999
F 202-742-3995
www.districtplasticsurgery.com

Pharmacy Name:
Address: **Zip:**
Telephone:
Fax:

ALLERGIES & SENSITIVITIES			
Any history of skin reaction or other illness after contact with:	**Yes**	**No**	**Description:**
Penicillin, Sulfa or other antibiotics			
Morphine, Codeine or Demerol			
Novocain, Lidocaine (local anesthesia)			
Adhesive tape			
Iodine or Betadine			
Latex			
Other			
SOCIAL HISTORY			
Do you smoke? O No O Yes How much?			
Do you drink? O No O Yes How much?			

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature:_____Date:_____

Consent to Communicate

DISTRICT PLASTIC SURGERY
PRAFUL RAMINENI, MD

2440 M Street NW, Suite 201
Washington, DC 20037
P 202-742-3999
F 202-742-3995
www.districtplasticsurgery.com

In general, the HIPAA privacy rule gives individuals the right to request a restriction of uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

O Home Telephone (_____)_____

O Ok to leave message with detailed information

O Leave message with call-back number only

O Written Communication

O Ok to mail to my home address

O Ok to mail to my work address

O Work Telephone (_____)_____

O Ok to leave message with detailed information

O Leave message with call-back number only

O Email

O Ok to email detailed information

O Ok to email special offers

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Uses and disclosures may be permitted without prior consent in an emergency.

I, _____, hereby give consent to _____ to
(Print Patient Name) (Relation and Print Name)
access/ obtain my medical records and speak on my behalf.

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

HIPAA Information and Consent Form

DISTRICT PLASTIC SURGERY
PRAFUL RAMINENI, MD

2440 M Street NW, Suite 201
Washington, DC 20037
P 202-742-3999
F 202-742-3995
www.districtplasticsurgery.com

Patient Name: _____Date of Birth:_____

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.
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. Please visit www.hhs.gov for additional information. We have adopted the following policies:

- ✓ 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.
- ✓ 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.
- ✓ 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.
- ✓ 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.
- ✓ You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
- ✓ Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
- ✓ We agree to provide patients with access to their records in accordance with state and federal laws.
- ✓ We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
- ✓ 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:_____