GORDON H. SASAKI, M.D., F.A.C.S.
Diplomate of
American Board of Plastic Surgery
800 S. Fairmount Ave. Suite #319
Pasadena, CA 91105
Tel (626) 796-3373 Fax (626) 796-1678
www.drsasaki.com

SASAKI ADVANCED AESTHETIC MEDICAL CENTER

PLEASE PRINT

Date_____

Patient's Name_____ Age _____ Date of Birth_____

Home Address_____ City_____ State_____ Zip_____

Home Phone (_____) _____ Cell Phone (_____) _____

Email_____

Married _____ Single _____ Widowed _____ Divorce _____ Separated _____

Patient's Occupation _____Employer _____

Business Address _____Business Phone (_____) _____

Name of Spouse _____ Spouse's Occupation _____

Spouse's Employer _____

Spouses Business Address _____ Business Phone (_____) _____

Patient Referred By _____ Phone Number (_____) _____

May we send a Thank You to the person who referred you? Yes_____ No_____

Family Doctor or Internist _____ Phone Number (_____) _____

Doctors Address _____

For emergency notification please list a relative not living at the same address as patient

Nearest Relative and Address_____ Phone Number (_____) _____

If patient is a minor, please complete the following on the financially responsible party:

Name _____ Relationship _____

Address _____ City_____ State_____ Zip _____

Occupation _____ Employer_____

Business Address _____ Business Phone (_____) _____

PRESENT PROBLEM

Specific Problem(s) For Which You Are Seeking Plastic Surgery

_____

Have You Consulted Any Other Doctors, Including Plastic Surgeons, About This? No ☐ Yes ☐

If Yes, Please List Their Names _____

PLEASE BE ADVISED THAT DOCTOR SASAKI

DOES NOT PARTICIPATE IN ANY INSURANCE PLANS

INJURIES

Type	Year	Hospital	Doctor	After Effects

FAMILY HISTORY

	Age	State of Health
Mother		
Father		
Brother (s)		
Sister(s)		
Children		

HAS ANY RELATIVE HAD:

Blood or Bleeding Disorders	No ☐	Yes ☐
Tuberculosis	No ☐	Yes ☐
Cancer	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Epilepsy	No ☐	Yes ☐
Heart Disease	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Lung Disease	No ☐	Yes ☐
Kidney Disease	No ☐	Yes ☐
Asthma	No ☐	Yes ☐
Mental Disease	No ☐	Yes ☐

MEDICATONS, DRUGS

ARE YOU ALLERGIC TO ANY MEDICATIONS? Please list and describe symptoms and reactions to each medication:

What is your daily consumption of the following:

Coffee or Tea _____ Alcohol _____ Tobacco _____

Other intoxicating or mind altering drugs (specify) _____

Does anyone else in your household smoke? No ☐ Yes ☐ How much? _____

Please list ALL your medications and their dosages including BIRTH CONTROL PILLS, DIURETICS, BLOOD PRESSURE OR HEART MEDICATIONS, TRANQUILIZERS, HORMONES, BLOOD THINNERS, NOSE DROPS/SPRAYS, INHALER MEDICINES, RUB-ON MEDICATIONS, ASPIRIN, BUFFERIN, SUPPLEMENTS, HERBS, AND VITAMINS, ETC.

PAST MEDICAL HISTORY

General Health Good ☐ Fair ☐ Poor ☐

If Not "Good", please explain:

Height _____ Weight _____ Weight Loss or Gain in past year _____ lb. Loss _____ Gain_____

History of Hepatitis, Jaundice, Blood infections or disorders, HIV? _____

Serious Illnesses (Please List)

PREVIOUS SURGERY (please list)

Operation	Year	Hospital	City	Surgeon's Name/ Type of Anesthesi (Local or General)

Have you had any significant Complications or after effects of these operations? No ☐ Yes ☐

If "Yes", Please Explain

_____

PERMANENT PREOPERATIVE INFORMATION

Have you ever reacted badly to being put to sleep for surgery?	No ☐	Yes ☐
Has any member of your family ever reacted badly to being put to sleep for surgery?	No ☐	Yes ☐
Have you required unusually large amounts of local anesthetic for medical or dental procedures?	No ☐	Yes ☐
Have you ever had a reaction to a local anesthetic (Novocain, etc.)?	No ☐	Yes ☐
Are you allergic to adhesive tape?	No ☐	Yes ☐
Are you allergic to adhesive material such as catgut?	No ☐	Yes ☐
Do you have high blood pressure?	No ☐	Yes ☐
Have you ever had scarlet fever or rheumatic fever?	No ☐	Yes ☐
Do you bleed unusually easily (from cuts, surgery, and tooth extractions)?	No ☐	Yes ☐
Do You Bruise Unusually Easily?	No ☐	Yes ☐
Are You a Slow or Poor Healer?	No ☐	Yes ☐
Do You Form Large Scars or Keloids?	No ☐	Yes ☐
Do You Have Any Skin Diseases, Hives, Eczema, or Rash?	No ☐	Yes ☐
Do You Have Frequent Infections or Boils?	No ☐	Yes ☐
Have You Taken Steroid Medications, Accutane, Cortisone, or ACTH? If so, how long ago?	No ☐	Yes ☐
Do You Have Shortness of Breath With Walking?	No ☐	Yes ☐
Do You Have, or Have You Had Any Back Trouble?	No ☐	Yes ☐
Does Your Religion Prohibit Blood Transfusions?	No ☐	Yes ☐
Do You Have or Have You Had Any Significant Emotional Problems?	No ☐	Yes ☐
Have You Ever Had, or Been Advised to Seek Psychiatric Care?	No ☐	Yes ☐

Have You Had Any Illnesses or Disorders of the Following? (Circle if Yes)

*Brain (Including Strokes, Epilepsy) * Face *Heart or Blood Vessels *Blood (Diabetes, Hepatitis, HIV) *Arms or Legs
*Nervous System *Nose, Sinus, Throat *Stomach *Urinary System *Bones or Joints
*Eyes (Including Glaucoma, Dryness) *Breasts *Intestines *Reproductive System *Endocrine System or Diabetes
*Ears * Lungs (Including Asthma) * Liver

If Circled, Please Explain:

_____
_____
_____

1. Do you use Retin-A? Yes ☐ No ☐
2. Have you ever used Accutane (Acne Drug)? Yes ☐ No ☐
3. Are you currently on a restricted diet? Yes ☐ No ☐
4. What is your ethnic origin? _____
5. Are you taking oral contraception? Yes ☐ No ☐ What Brand? _____
6. Are you or are you trying to become pregnant? Yes ☐ No ☐
7. Are you due for your menstrual period within this next week? Yes ☐ No ☐
8. Do you have regular exercise and sleep patterns? Yes ☐ No ☐
9. What concerns do you have about your skin? _____
10. Do you tan? Yes ☐ No ☐
11. Do you tan evenly? _____ Blotchy? _____
12. Have you had a chemical peel? Yes ☐ No ☐
13. What products are you currently using? _____
14. Are you troubled by a breakthrough oily shine during the day? Yes ☐ No ☐
15. Do you ever experience a skin breakout? Yes ☐ No ☐
16. How much plain water do you consume daily? _____ Glasses
17. Do you take any laxatives or diuretics? Yes ☐ No ☐
18. Do you ever experience any flaking or tightness of your skin? Yes ☐ No ☐
19. If you sunbathe, do you use a protection on your skin? Yes ☐ No ☐
20. Do you burn easily in moderate sunlight? Yes ☐ No ☐
21. Do you blush easily when nervous? Yes ☐ No ☐
22. Do you have a tendency to redness? Yes ☐ No ☐
23. Have you ever suffered any sinus problems? Yes ☐ No ☐
24. Do you take any stimulants or slimming tablets? Yes ☐ No ☐
25. Do you consider your pain threshold low, medium, or high? _____
26. Do you prefer a massage to be firm or light pressure? _____
27. Have you ever had a reaction to a stimulus such as: (please check)

☐ Cosmetic ☐ Foods ☐ Pollen
☐ Metals ☐ Animals ☐ Other _____

Patient **OR** Guardian Signature:_____

Print Name: _____ Date: _____

Consent for Consultation and/or Treatment I Consent to the Care and Treatment by Gordon H. Sasaki, M.D.,his Registered Nurses, Surgical Team, or Skin Care Specialists

Patients **OR** Guardian Signature:_____

Print Name: _____ Date: _____

PHOTOGRAPHIC RELEASE AND CONSENT

I authorize Gordon Sasaki, M.D. to use my photographs, videotapes and case information in the following educational and scientific settings that I have initialed: Declining photographic consent will in no way affect the doctor/patient relationship or treatment. I understand and accept that I may be recognized from my likeness or case history

Yes No

_____ _____ Photographs to be taken as part of the documentation process.

_____ _____ Lectures and multi- media presentations for an audience of medical professionals but at which members of the press may be present.

_____ _____Lectures and multi-media presentations given by my surgeon(s) for the general public

_____ _____ Medical, surgical and scientific journal articles

Yes No

_____ _____Dr. Sasaki's personal web site or web page

_____ _____ Dr. Sasaki's Facebook and Instagram page

_____ _____Dr. Sasaki's office patient education materials

_____ _____Newspaper and magazine articles in which my surgeon participates

_____ _____Television programs in which my surgeon participates

_____

Patient **OR** Guardian Signature Date

_____

Print Name

IMPORTANT INFORMATION ABOUT PATIENT EMAIL

As a patient of Sasaki Advanced Aesthetic Medical Center, Sasaki InnoVessence SkinCare Inc., Dr. Gordon H. Sasaki, and Gordon H. Sasaki, MD, Inc., you may request we communicate with you by electronic mail (email). This Fact Sheet will inform you about the risks of communicating with our office and how we will use and disclose provider/patient email.

PLEASE READ THIS INFORMATION CAREFULLY

Email communications are two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition.

If you have an urgent or an emergency situation, you should not rely solely on provider/patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider/patient email is not available to you- and seek assistance by means consistent with your needs.

Email messages on your computer, laptop, and/or phone have inherent privacy risks-especially when your email access id provided through your employer or when access to your email messages is not password protected.

Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the post office.

Email messages may be inadvently missed. Email is sent at the touch of the button. Once sent, and email message cannot be recalled or cancelled. Errors in transmissions, regardless of the sender's caution, can occur.

In order to forward or to process and respond to your email, associate staff may read your email message. Your email message is not a private communication between you and your treating provider.

Neither you nor the person reading your email can see the facial expressions or gestures or hear the voice of the sender. Email can be misinterpreted.

As your health care provider's discretion, your email messages and any and all responses to them may become part of your medical record.

CONSENT TO COMMUNICATE

PATIENT:_____

EMAIL:_____

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some methods of contact must be provided, and as appropriate, information as to how payment will be handled.

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

Method	Phone Number	Leave Voice Mail	Preferred Contact Method(s)
☐ Call Work Phone	( )	☐Yes ☐No	☐
☐Call Cell Phone	( )	☐Yes ☐No	☐
☐Call Home Phone	( )	☐Yes ☐No	☐
May we send Email?		☐Yes ☐ No	
May we send Regular Mail?		☐Yes ☐No	
May we send Appointment Reminders via Text Message?		☐Yes ☐No	

Please list any person(s) you give us permission to communicate with about your health care information.

Name	DOB	Relationship	Any Comments

Please list your **Emergency Contact(s):**

Name	DOB	Relationship	Contact Number(s)	
			( )	( )
			( )	( )

Signature:_____Date:_____

PATIENT REQUEST FOR EMAIL COMMUNICATION

PATIENT:_____DOB:_____

EMAIL:_____CONTACT NO._____

Although our servers are encrypted and Dr. Sasaki have taken the appropriate measures, not all communications over the Internet and/or using the email system are encrypted and may not be secure. There is no assurance of confidentiality when communicated via email.

Please be advised that: This request applies to , Dr. Gordon H. Sasaki, Inc., Sasaki Advanced Aesthetic Medical Center, Sasaki InnoVessence SkinCare Inc., Dr. Gordon H. Sasaki, and/or associated staff.

I understand and agree to the following:

- I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.
- I have received a copy of the IMPORTMANT INFORMATION ABOUT PATIENT EMAIL form and I have read and understand it.
- I understand and acknowledge that communication over the Internet and/or using email system may not be encrypted and may not be secure; that there is no assurance of confidentially of information when communicate this day.
- I understand that all email communication in which I engage may be forwarded to other providers for purposes of providing treatment to me.

I agree to hold Dr. Gordon H. Sasaki, Inc. Sasaki Advanced Aesthetic Medical Center, Sasaki InnoVessence SkinCare Inc., Dr. Gordon H. Sasaki, and/or individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

Signature_____ Date_____