

Camille G. Cash, M.D., P.A.

Cosmetic and Reconstructive Surgery

1315 St. Joseph Pkwy, Suite 1305, Houston, TX 77002

PATIENT INFORMATION

NAME _____ HOME PHONE _____
(Last) *(First)* *(MI)*

SS# _____ BIRTHDATE _____ AGE _____ CELL PHONE _____

HOME ADDRESS _____ EMAIL ADDRESS _____

CITY _____ ST _____ ZIP _____ MARITAL STATUS: S M D W O

PHARMACY NAME AND PHONE NO. _____

EMPLOYER _____ PHONE _____

ADDRESS _____ OCCUPATION _____

GUARANTOR'S NAME _____ DOB _____ SS# _____

EMPLOYER _____ ADDRESS _____

PHONE _____

PRIMARY INSURANCE _____ ID # _____

POLICY HOLDER NAME _____ GROUP# _____

INSURANCE PHONE _____ CLAIMS ADDRESS _____

SECONDARY INSURANCE _____ ID# _____

POLICY HOLDER NAME _____ GROUP# _____

INSURANCE PHONE _____ CLAIMS ADDRESS _____

NAME OF RELATIVE _____ RELATIONSHIP _____

(For emergency)

HOME PHONE _____ CELL _____ WORK _____

REFERRED BY (PCP) _____

ALLERGIES OR OTHER CONDITIONS _____

**I authorize the release of all medical information
necessary to process any claim that may be made.**

**I authorize payment of medical benefits to the
physician for the service rendered.**

Signature _____

Date _____

HEALTH HISTORY

(Confidential)

Name _____ Today's Date: _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomitting <input type="checkbox"/> Vomitting blood	<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision – Flashes <input type="checkbox"/> Vision – Halos	<p>Men Only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other
<p>MUSCLE/JOINT/BONE Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose Veins	<p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sores that won't heal	<p>Women Only</p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast Lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other
<p>GENITO-URINARY</p> <input type="checkbox"/> Blood in urin <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination			<p><i>Date of last menstrual period:</i> _____ <i>Date of last pap smear:</i> _____ <i>Have you had a mammogram?</i> _____ <i>Are you pregnant?</i> _____ <i>Number of children</i> _____</p>

CONDITIONS Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease
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MEDICATIONS List medications you are currently taking	ALLERGIES To medications or substances
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Pharmacy Name and Phone: _____

CAMILLE G. CASH, M.D.,P.A.
1315 ST. JOSEPH PKWY, SUITE 1305
HOUSTON, TX 77002
(713) 571-0600

Authorization For Use and Disclosure of Protected Health Information (PHI)

1. Use and Disclosure

Your Protected Health Information (PHI) will be used by the practice and disclosed to others for the purpose of treatment, payment, healthcare operations, law enforcement, or for public health safety. The Practice will require your consent or authorization to disclose PHI for other purposes.

2. Notice of Privacy

The Practice will give you a Notice of Privacy about its policies for disclosure of PHI. You should review this document carefully. It recognizes your rights as a patient and details how your PHI will be disclosed. You must sign this notice and receive a signed copy of the notice. If you decline not to acknowledge this notice, the Practice will not treat you.

3. Request for Restriction to Use or Disclose PHI

You may request a written restriction on the use and disclosure of your PHI. The practice will agree to your request. It will not use or disclose the restricted PHI. Violation of this agreement will be a violation of the federal privacy standard.

4. Revocation of Authorization or Consent

You may revoke this consent by written statement at any time. The Practice will honor your request. Any use or disclosure of you PHI prior to this date will not be affected by this revocation.

5. Reservation of Right to Change Privacy Practice

The Practice reserves the right to modify the privacy practices outlined in the notice.

6. Signature of Patient or Patient Representative

I have reviewed this authorization form and give my permission to the Practice to use or disclose my health information in accordance with the above authorization and guidelines of HIPAA regulation.

Name of Patient

Signature of Patient

Date

Signature of Patient Representative

Relationship

CAMILLE G. CASH, M.D.,P.A.
1315 ST. JOSEPH PKWY, SUITE 1305
HOUSTON, TX 77002
(713) 571-0600

**AUTHORIZATION FOR AND RELEASE OF
MEDICAL PHOTOGRAPHY/SLIDES/AND/OR VIDEOTAPES**

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined within this consent document.

INTRODUCTION

Medical photographs/slides and videotapes may be taken, before, during or after a surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photography/slides, and videotapes for a stated purpose.

1. **CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES**

I hereby authorize **Camille G. Cash, M.D.** and/or her associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes. I additionally consent to photographs, slides, and/or videotapes of my interview.

2. **CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES**

I hereby authorize **Camille G. Cash, M.D.,** and/or her associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, for purposed of medical education, patient education, lay publication, or during lectures to medical or lay groups, and for Board Certification.

3. **CONSENT FOR USE OF NON-IDENTIFIABLE PHOTOS**

I hereby authorize **Camille G. Cash, M.D.,** to use my illustration, photograph or other imaging records created in my case, for use on the website of Camille G. Cash, M. D. All identifiable characteristics, with the exception a full face photograph of a uniquely identifiable characteristic, will be blanked out to protect patient privacy.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Date _____

Patient Name _____

Patient Signature _____

Witness _____

DIRECTIONS TO:
CAMILLE G. CASH M.D.
1315 St. Joseph Parkway, Suite 1305
Houston, Texas 77002
713-571-0600

FROM I-45 NORTH

Take I-45 South towards Dallas/Downtown
Exit Dallas/Pierce, Stay on Pierce to Austin
Turn left on Austin
Come across St. Joseph Parkway and turn left into garage

FROM I-45 SOUTH

Take I-45 North toward Downtown, Exit Downtown Destinations – Scott/Downtown
Stay in left lane of ramp and exit St. Joseph Parkway
Continue to Austin St.
Turn right on Austin
Turn left into garage

FROM 59 NORTH

Take 59 South to McGowan/Tuam exit
Turn right on McGowan to Austin
Turn right on Austin
Cross St. Joseph Parkway and turn left into garage

FROM 59 SOUTH

Take 59 North to Gray/Pierce exit
Turn left on St. Joseph Parkway to Austin
Turn right on Austin
Turn left into garage

FROM I-10 EAST

Take I-10 West to 59 South
Exit McGowan and continue to Austin
Turn right on Austin
Cross St. Joseph Parkway and turn left into garage

FROM I-10 WEST

Take I-10 East to 45 South
Exit Dallas/Pierce and continue to Pierce
Continue on Pierce to Austin St.
Turn left on Austin
Cross over St. Joseph Parkway and turn left into garage

FROM 288 SOUTH

Take 288 North to 59 North
Exit Gray/Pierce to St. Joseph Parkway
Turn left on St. Joseph Parkway to Austin
Turn right on Austin
Cross over St. Joseph Parkway and turn left into garage