PARTINGTON
PLASTIC SURGERY CENTER

Creating Beauty with Integrity Since 1991

Welcome

We are much honored that you have chosen Partington Plastic Surgery Center to help you look and feel your best. Regardless of the procedure(s) you have chosen it is our goal to provide you with the very best experience.

For your convenience please complete the enclosed information and bring it with you to your appointment. Please bring your insurance card, driver's license, filled out forms, and a form of payment. We suggest that you arrive at least 15 minutes early so that we may review your paperwork and make the necessary copies. We have also enclosed driving directions to our Kirkland, WA clinic.

Your complete consultation is scheduled for one hour. Your consultation will begin with one of our Patient Care Coordinators followed by a complete examination by Dr. Partington. To make this appointment with Dr. Partington the most beneficial we suggest that you create a list of questions that you would like answered.

If you need to reschedule your appointment or if any last minute complications occur, we ask that you give as much notice as possible (minimum of 24 hours), otherwise a $75.00 fee will be charged to you.

It is our pleasure and privilege to have you as a patient. Please feel free to give us your feedback at any time throughout your journey and thank you, again, for allowing us to service your surgical and non-surgical needs.

Cheers~

The Team at Partington Plastic Surgery Center

10220 NE POINTS DR, SUITE 110, KIRKLAND, WA 98033 TEL: 425-883-2294 FAX: 425-883-3933

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Welcome to Partington Plastic Surgery. We are delighted you are here. Please take a brief moment and complete the following registration forms.

Patient:____
Last Name First Name Middle Initial

Birthdate:_____________ **Age:** ______________

Address: ____
Street City State Zip

SSN#:____________________ ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**

Phone: Home: (_____) _____________________ **Work:** (_____) ______________________

Cell: (_____) ______________________________ **Email:** _____________________________

*** May we contact you for promotions and special events? ☐ YES ☐ NO

Employer: ______________________________**Occupation:** ___________________________

Spouse's Name: __________________________ **Employer:** ____________________________

****** IN CASE OF AN EMERGENCY******
******Who will we be notifying******

Name: ________________________________ **Relationship:** ___________________________

Home Phone: (_____) ____________________**Work Phone:** (_____) ____________________

Cell Phone: (_____) _____________________

Please tell us how you heard about Dr. Partington?

☐ **Physician** _____________________________ ☐ **Web** ________________________________
☐ **Friend /Relative** ________________________ ☐ **Newsletter** ___________________________
☐ **Other** _________________________________

PATIENT SIGNATURE: _______________________ **DATE:** __________________

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Insurance Registration Form

Primary Health Insurance Company: ____

Primary Cardholder: _____________________ DOB: ___________ Employer:______________

Policy #:______________________ Group #:_________________ Ins. Phone:_______________

Referral Required? ☐ No ☐ Yes Co-Pay? ☐No ☐Yes $___________

Secondary Health Insurance Company: ____

Primary Cardholder:_______________________ DOB: ___________ Employer: ____________

Policy #:______________________ Group #:_________________ Ins. Phone:_______________

Referral Required? ☐ No ☐ Yes Co-Pay? ☐No ☐Yes $ ___________

I hereby authorize payment of any surgical and/or medical benefits directly to Dr. Marshall T. Partington of Partington Plastic Surgery Center for his services. ***I AGREE TO PAY ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE***. I understand that Dr. Marshall T. Partington does not bill secondary insurance and that I am responsible to bill my own secondary insurance if applicable. I understand that Dr. Marshall T. Partington will bill my health insurance as a one-time courtesy and that rebilling is not customary. **I understand that I am responsible to follow up with my insurance company if there are any discrepancies or lack of payment for services rendered. I understand that it is my responsibility to make sure that I have coverage to see Dr. Marshall T. Partington. It is also my understanding the Dr. Marshall T. Partington runs a "for profit" health care service, and that any service, supplement, or skin care product falls under the "for profit" umbrella.**

Authorization to Release Medical Information to Insurance Co. and Other Medical Offices:

I hereby authorize Dr. Marshall T Partington of Partington Plastic Surgery Center to release any information acquired during the course of my examination on treatment.

NAME: __________________________________ **DATE OF BIRTH:** ____________

PATIENT SIGNATURE: _________________________ **DATE:** _______________

Authorization for Quality Assurance And Peer Review:

I hereby authorize Marshall T. Partington of Partington Plastic Surgery Center to disclose information to those individuals qualified for the purpose of medical quality assurance and peer review.

PATIENT SIGNATURE: _________________________ **DATE:** _______________

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PATIENT PRIVACY AND CONSENT, FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I ___________________________, hereby consent to the use or disclosure of my protected health information by the practice of Marshall T Partington, M.D., hereinafter referred to as ("practice"), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not by billed to any third party. I understand that payment for such procedures will be requested in advance for any treatment. I understand there are no warrantees implied or otherwise to the out come of any treatments or procedure.

I have been offered, read and/or understand the Practice's Notice of Privacy Practices, which has been offered to me by the practice, prior to signing this document. I understand that the patient privacy rights and disclosure varies state by state.

I understand that the Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment. This Notice of Privacy Practices also describes my rights and the practice's duties with respect to my protected health information. The Notice of Privacy Practices for Partington Plastic Surgery Center is available at the offices of Partington Plastic Surgery Center.

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

Patient Name: _____________________________________ **Date of Birth:** _______________

Signature: ____ **Date:** _______________

Other than Patient:

Name: ______________________________ **Signature:** _____________________________

Relationship to Patient:_________________________________ **Date:**________________

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Health Questionnaire

Full Name: ______________________________ Date of Birth: __________________

Age: ___________ Height: ___________ Weight: ___________

Primary Care Doctor: ____

Specialists: ____

Please list any medical illness that you have been or are being treated for:

____

____

____

____

Please list all allergies including food, drug and/or topical (i.e. Latex and adhesive):

____

____

Please list all medications including over the counter drugs, dietary supplements and herbal additives:

____

____

____

Please list all previous minor and major operations along with their approximate dates. This includes any form of cosmetic procedures:

____ Date: ____________

____ Date: ____________

____ Date: ____________

____ Date: ____________

____ Date: ____________

____ Date: ____________

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Anesthesia History:
(Please circle all that apply)

- ☐ No past anesthesia history
- ☐ Post-operative nausea and vomiting
- ☐ Local anesthetic complications
- ☐ Complications during or after anesthesia. Please Explain:

____
____
____
____

Do you currently have or have you ever been treated for any of the following:
(Please circle all that apply)

☐ Chronic Pain	Hepatitis A or B	☐ Weakness
☐ Asthma and/ or Bronchitis	☐ HIV/AIDS	☐ Sleep Apnea
☐ Acid Reflux	☐ Psychiatric Care	Stroke
☐ Chest pain or any Heart Disease	☐ Eye Problems	☐ Pneumonia
☐ Heart Attack	☐ Cold Sore	☐ Productive Cough
☐ Irregular Heart Beat	☐ Diabetes/High Blood Sugar	☐ Emphysema
Blood Clots	Thyroid	Tuberculosis
☐ High Blood Pressure	☐ Kidney	☐ Shortness of Breath
High Blood Sugar	Seizures	☐ UTIs
☐ ☐	Sickle Cell	☐ Cancer
		☐ Numbness
		None

Social History:

Do you smoke cigarettes? _____YES _____NO Packs per day: _________________

Do you drink alcohol? _____YES _____NO Drinks per day: ________________

Do you use recreational Drugs? _____YES _____NO Usage much per day: ____________

Name:________________________________ Date of Birth:_____________________

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NAME: ____________________________________ DATE OF BIRTH: ____________

SIGNATURE: ___________________________________ DATE: _________________

Medical Concerns	Family History Of	No Family History Of	Afflicted Family Member	Notes / Other Family Members
Anesthesia Problems	☐	☐		
Malignant Hyperthermia	☐	☐		
Abnormal Bleeding	☐	☐		
Abnormal Clotting	☐	☐		
Autoimmune Disorders	☐	☐		
Cancer	☐	☐		
Breast Cancer	☐	☐		
Pulmonary Embolism	☐	☐		
Diabetes	☐	☐		
Endocrine Disease	☐	☐		
Heart Disease	☐	☐		
High Blood Pressure	☐	☐		
Von Willebrand	☐	☐		
Hemophilia	☐	☐		
Liver Disease	☐	☐		
Lung Disease	☐	☐		
Skin Cancer	☐	☐		
Skin Disease	☐	☐		
Substance Abuse	☐	☐		
Aneurysm	☐	☐		

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Cosmetic Interest Form

Please tell us why you are here to see Dr. Partington today. Circle all that apply:

Facial Cosmetic Surgery:

- ☐ Brow &Forehead Lift
- ☐ Chin Augmentation
- ☐ Cheek & Midface Lift
- ☐ Eyelid Lift
- ☐ Face & Necklift
- ☐ Fat Injections
- ☐ Neck Liposuction
- ☐ Otoplasty
- ☐ Rhinoplasty

Body Cosmetic Surgery:

- ☐ Abdominoplasty
- ☐ Arm Lift
- ☐ Body Lift
- ☐ Breast Augmentation
- ☐ Breast Lift
- ☐ Breast Reconstruction
- ☐ Breast Reduction
- ☐ Buttock Lift
- ☐ Fat Injections

Injectables:

- ☐ Botox
- ☐ Dysport
- ☐ Juvederm
- ☐ Perlane
- ☐ Restylane

Facial Rejuvination:

- ☐ Dermaplane
- ☐ Chemical Peels
- ☐ Skin Care Analysis
- ☐ SkinCeuticals Product
- ☐

Please tell us about your skin care regimen: ____

____

*******I am looking for a procedure that can give me a*******

Small improvement With some Down-time		Moderate Improvement With some Down-time		Significant Improvement With longer Down-time
1	2	3	4	5
○	○	○	○	○

If there is anything we missed that you would like to speak with Dr. Partington about today, please note it here:

____

____

Name:____________________________________ **Date of Birth:**____________________

May we e-mail you with promotions and upcoming events? ☐ **YES** ☐ **NO**

E-Mail ____

From I-405 going South (from Everett)

1-405 South towards BELLEVUE/RENTON
Merge onto 520 West via EXIT 14 towards SEATTLE
(FOLLOW DIRECTIONS BELOW FOR 520-WEST)

From I-405 going North (from Renton)

1-405 North towards BELLEVUE
Merge onto 520 West via EXIT 14 towards SEATTLE
(FOLLOW DIRECTIONS FOR BELOW 520-WEST)

From WA-520 going East (from Seattle or I-5)

520 East towards BELLEVUE/KIRKLAND
Take the exit toward LAKE WASHINGTON BLVD. NE
Merge onto BELLEVUE WAY NE, get into your left lane
Take a LEFT turn onto NE POINTS DR
10220 NE POINTS DR is immediately on your RIGHT
We are the first building on your left in the PLAZA YARROW BAY office complex. Look for a purple UW sign on the outside of the building. Go straight through the main entrance/front doors past the elevators. We are located at the end of the hall.

From WA-520 going West (from Redmond)

520 West towards SEATTLE
Take the 108TH AVE NE exit
Turn RIGHT off the exit onto 108TH AVE NE
Take your next immediate LEFT onto NORTHUP WAY
NORTHUP WAY becomes NE POINTS DRIVE.
10220 NE POINTS DRIVE is the first immediate RIGHT after you go through the Bellevue Way/Lake
Washington Blvd intersection.
We are the first building on your left in the PLAZA YARROW BAY office complex. Look for a purple UW sign on the outside of the building. Go straight through the main entrance/front doors past the elevators. We are located at the end of the hall.

*Throughout the 2011-2012, construction will be taking place on WA-520. Expect delays and detours that are not visible online. Please feel free to call the office for assistance with directions.

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