



Sam M. Sukkar, MD  
 Plastic, Hand, and Reconstructive Surgery  
 1616 Clear Lake City Blvd., Suite 102  
 Houston, TX 77062-8068  
 (281) 990-8487 (281)204-8018 (Fax)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (If Different) \_\_\_\_\_

Home Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Martial \_\_\_\_\_

SS# \_\_\_\_\_ Referred by \_\_\_\_\_

Email address \_\_\_\_\_

Drivers License # \_\_\_\_\_ Exp \_\_\_\_\_

**\*Please present for a copy\***

Emergency Contact/ Relationship: \_\_\_\_\_ / \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_

Employed by: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone# \_\_\_\_\_ EXT \_\_\_\_\_

INSURANCE INFORMATION (RECONSTRUCTIVE PATIENTS ONLY)  
 (A COPY OF YOUR INSURANCE CARD WILL BE REQUESTED)

MEDICARE # \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ S.S.# \_\_\_\_\_

Policy # \_\_\_\_\_ Group# \_\_\_\_\_

DOB of Policy Holder \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**\*\* PLEASE PRESENT COPY OF SECONDARY/SUPPLEMENTAL INSURANCE CARD, IF APPLICABLE.**

**I authorize payment directly to the Physician of the Surgical/Medical Benefits, if any, otherwise payable to me for his services as described, realizing I am responsible to pay non-covered services and I authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



Sam M. Sukkar, M.D., F.A.C.S.  
1616 Clear Lake City Blvd, Suite 102  
Houston TX 77062  
281-990-8487 phone /281-204-8018fax

## PHOTO CONSENT

For documentation purposes, Dr. Sukkar requires before and after photographs for my confidential medical records. I have been informed of this policy.

Patient Name: \_\_\_\_\_ (print)

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I also grant permission for Dr. Sukkar the use of my patient photographs for the following types of media including but not limited to the following:

- PRINT
- VISUAL
- ELECTRONIC
- INTERNET

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Sam M. Sukkar, M.D., F.A.C.S.  
1616 Clear Lake City Blvd, Suite 102  
Houston TX 77062  
281-990-8487 phone /281-204-8018fax

**GENERAL INTAKE INFORMATION**

DATE\_\_\_\_\_

NAME\_\_\_\_\_ AGE\_\_\_\_\_

LAST FIRST MIDDLE

Referring Physician\_\_\_\_\_ Phone\_\_\_\_\_

**CHIEF COMPLAINT/REASON FOR VISIT**\_\_\_\_\_

**PRESENT ILLNESS**\_\_\_\_\_

**PAST HISTORY**

1. SERIOUS ILLNESS\_\_\_\_\_

2. OPERATIONS\_\_\_\_\_

3. OTHER HOSPITALIZATIONS\_\_\_\_\_

4. PRESENT MEDICATIONS\_\_\_\_\_

MEDICATIONS AFFECTING BLEEDING: please circle ASA VITAMIN E IBUPROFEN

BLEEDING DISORDERS? Y N

VEIN DISORDERS? Y N

DIETARY/HERBAL SUPPLEMENTS\_\_\_\_\_

5. ALLERGIES\_\_\_\_\_

LATEX ALLERGY? Y N

**FAMILY HISTORY**\_\_\_\_\_



Sam M. Sukkar, M.D., F.A.C.S.  
 1616 Clear Lake City Blvd, Suite 102  
 Houston TX 77062  
 281-990-8487 phone /281-204-8018fax  
**PERSONAL HISTORY QUESTIONNAIRE**

DATE \_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_  
 LAST FIRST MIDDLE

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SEX: M F MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

DATE OF LAST PHYSICAL EXAM \_\_\_\_\_ PHYSICIAN \_\_\_\_\_

**PAST MEDICAL HISTORY: Do you have or have you had? (If yes, give date of occurrence.)**

AIDS OR HIV	N	Y _____	SCHLERODERMA	N	Y _____
THYROID	N	Y _____	ASTHMA	N	Y _____
HEART	N	Y _____	LUPUS	N	Y _____
KIDNEYS	N	Y _____	CANCER	N	Y _____
GALLBLADDER	N	Y _____	ARTHRITIS	N	Y _____
STOMACH	N	Y _____	BLOOD PRESSURE	N	Y _____
HEPATITIS	N	Y _____	LUNGS	N	Y _____
BLEEDING TENDENCIES	N	Y _____	NERVOUS PROB	N	Y _____
FIBROMYALGIA	N	Y _____	BLEEDING PROBS	N	Y _____

Do you regularly smoke? Y N How much per day? \_\_\_\_\_

Do you regularly drink over 3 cups of coffee per day? Y N

Do you regularly drink alcohol or beer? Y N How much per week? \_\_\_\_\_

**MEDICATIONS: Are you presently taking any of the following? (Circle)**

Aspirin/Anacin	Cough Medicine	Antibiotics	Phenobarbital
Bufferin	Dilantin	Thyroid Pills	Blood Pressure Pills
Motrin	Blood Thinners	Iron	Hormones
Ibuprofen	Insulin/diabetic pills	Digitalis	Sleeping Pills
Birth Control Pills	Arthritis medication	Cortisone	Water Pills

Other Medication not listed \_\_\_\_\_

*Aspirin and aspirin type products can cause excessive bleeding during surgery.*

**WOMEN ONLY**

Is there a chance you may be pregnant? Y N Regular Menses? Y N Date of last period \_\_\_\_\_

Any complications with pregnancies? \_\_\_\_\_

How many pregnancies? \_\_\_\_\_ How many children? \_\_\_\_\_ Did you breastfeed? Y N How many? \_\_\_\_\_

Date of last mammogram \_\_\_\_\_ Normal or Abnormal Specify \_\_\_\_\_

Breast Cancer L R Date \_\_\_\_\_ Mastectomy \_\_\_\_\_ Date \_\_\_\_\_

Breast Biopsy L R Date \_\_\_\_\_ Oncologist \_\_\_\_\_

Surgeon for Breast Biopsy \_\_\_\_\_ Phone # \_\_\_\_\_



Sam M. Sukkar, M.D., F.A.C.S.  
1616 Clear Lake City Blvd, Suite 102  
Houston TX 77062  
281-990-8487 phone /281-204-8018fax  
**PRIVACY PRACTICES**

**Contact Person**

The name and address of the person you can contact for further information concerning our privacy practices is:

**Office Manager**  
**Sam M. Sukkar, M.D. and Sukkar Aesthetic Plastic Surgery**  
**1616 Clear Lake City Boulevard, Suite 102**  
**Houston, Texas 77062**  
**(281) 990-8487**

**Effective Date**

This Notice is effective on or after 4/13/2003

**Sam M. Sukkar, M.D. and Sukkar Aesthetic Plastic Surgery Duties:**

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

**Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

**Requests to Inspect Protected Health Information**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the **Receptionist Associate** or **Office Manager**. Your request will be reviewed and generally be approved unless there are legal or medical reasons to deny the request.

**Complaints**

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

**Sam M. Sukkar, M.D.**  
**The Clinic for Plastic Surgery, P.A.**  
**1616 Clear Lake City Boulevard, Suite 102**  
**Houston, Texas 77062**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

**PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices**

**The Clinic for Plastic Surgery, P.A. and Sam M. Sukkar, M.D.** reserves the right to modify the privacy practices outlined in the notice.

**Signature**

I have received a copy of the Notice of Privacy Practices for **The Clinic for Plastic Surgery, P.A. and Sam M. Sukkar, M.D.**

\_\_\_\_\_  
PATIENT NAME (PRINT OR TYPE)

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
Date

\_\_\_\_\_  
SIGNATURE OF PATIENT REPRESENTATIVE  
(Required if the patient is a minor or an adult who is unable to sign this form)

\_\_\_\_\_  
Relationship of Patient Representative to Patient