



P: 813-579-3369 & F: 866-202-3227
www.wayneleemd.com

Brandon Office
1020 E. Brandon Blvd, Suite 101
Brandon, FL 33511

New Patient Form

Date: _____
Patient Name: _____ MI: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell phone #: _____ Home phone #: _____
Email: _____
(If you would prefer not to receive email communication from WLMD and Real Self, please leave the email line blank.)
Social Security #: _____
Driver's License #: _____ State: _____ Exp: _____
Age: _____ Birthdate: (mm/dd/yy): ____/____/____ Gender: M / F Ethnicity: _____ (opt)
Height: _____ ft _____ in. Weight: _____ lbs
Occupation: _____ Employer: _____
Marital Status (circle): Single, Married, Widowed, Divorced, Separated Spouse's Name: _____

Emergency Contact:
Name: _____ Relationship: _____ Phone #: _____
Nearest relative not living with you: _____ Relationship: _____
Phone #: _____ Address: _____
City: _____ State: _____ Zip: _____

Confidential Health Information Release

Name (Print): _____ MI: _____
I authorize this medical office or its affiliates to leave confidential health information voicemail at the following phone number if I'm not available: _____ Type of Phone: Home / Work / Cell
I authorize this medical office or its affiliates to share PATIENT medical Information with (name and relationship): _____
I authorize this medical office or its affiliates to send confidential health information to the following:
Address: _____ City: _____ State: _____ Zip: _____
Signature: _____ Date: _____

Reason for today's visit: _____
Referring Physician: : _____ Family Physician: _____
Other Physician: _____

Patient Name: _____

Pharmacy Information

Pharmacy name: _____
Phone number: _____

Address: _____
Fax number: _____

Social History

SMOKING/VAPING: (circle) YES NO QUIT: ____ Type: Cigarettes ____ Cigars ____ Chewing Tobacco ____
ALCOHOL: (circle) YES NO QUIT: ____ # of drinks per week: ____
ILLEGAL DRUGS: (circle) YES NO QUIT: ____ Type: ____ Frequency: ____ IV Drugs?Y/N
MARIJUANA: (circle) YES NO QUIT: ____

Surgeries

Type	Month/Year	Surgeon/Hospital

Pregnancies

Number of Pregnancies: _____ Number of Children: _____
Males _____ Ages: _____ Females _____ Ages: _____

Medications/Supplements

Are you currently taking any medications: Yes ____ No ____

Please list all medications/supplements: _____

Are you currently taking any of the following blood thinners? (circle)

- | | | | | |
|----------|-----------|---------------------|----------|---------|
| Aspirin | Plavix | Warfarin (Coumadin) | Fish Oil | Fragmin |
| Coumadin | Dicumarol | Miradon | Clexane | Arixta |
| Orgaran | Innohep | Argatroban | Reludan | |
| Pradox | Plavix | Persantine Aggrenox | Angiomax | |

Allergies

Penicillin (reaction):	Cephalosporin(e.g. Keflex)(reaction):
Sulfa (reaction):	Aspirin (reaction):
Codeine (reaction):	Morphine (reaction):
Latex (reaction):	<input type="checkbox"/> No Known Drug Allergies

Please list all allergies/reaction: _____

Patient Name: _____

Family Medical History

Have you or anyone in your family had problems with anesthesia? _____ Yes, _____ No

Check below if any of the following conditions have occurred on either side of the patient's family:

- | | | | |
|---|--------------------------|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> | <input type="checkbox"/> Bone Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Melanoma Skin Cancer | <input type="checkbox"/> | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Pulmonary Disease |
| <input type="checkbox"/> Other Cancer | <input type="checkbox"/> | <input type="checkbox"/> Congenital Deformities | <input type="checkbox"/> Bleeding Tendencies |
| <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> | <input type="checkbox"/> Heart Disease/Cardiovascular | <input type="checkbox"/> Keloid Scars |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> Pulmonary Embolism |

Other (please list all): _____

Personal Medical History

Check below all illnesses that you have/had:

- | | | | | |
|--|--|--|---|---------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Depression | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Reflux | <input type="checkbox"/> Gastroesophageal | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Migraines | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> COPD | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Irritable Bowel Syndrome | |
| <input type="checkbox"/> Ulcers (leg) | <input type="checkbox"/> Rheumatic Fever | | <input type="checkbox"/> Hepatitis, Type: _____ | |
| <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cancer/Tumors. Type: _____ | |

Sexually Transmitted Disease, Type: _____

Are you HIV positive? Yes _____ NO _____

Do you have a pacemaker? YES _____ NO _____

List all other illnesses you've had: _____

Edited 3/16/2026

Review of Symptoms

- Constitutional: Weight Loss Fatigue Fever
 Weight Gain
- Cardiovascular: Chest Pain Cyanosis Shortness of Breath
 Ankle Edema Frequent Urination at Night
- Respiratory: Cough Coughing Blood Wheezing
 Use of Oxygen Shortness of Breath
- Musculoskeletal: Pain Tenderness Muscle Weakness
 Joint Swelling

- Endocrine: High Blood Sugar Excessive Thirst Intolerance of Heat or Cold
- Hematology/Lymphatic: Anemia Bruise Easily Enlarged Lymph Node
- Allergy/Immunologic: Itchy Frequent Infection Inhalant or Food Allergy
- GU: Burning Urinary Infections Urine in Blood
- Eyes: Blindness Red Eyes Double or Blurry Vision
- Skin: Rash Lumps Sores
 Loss of Hair
- Psych: Anxiety Sleep Disturbances Nervousness
 Memory Loss
- GI: Nausea Vomiting Diarrhea
 Vomiting Blood Indigestion Difficulty Swallowing
- Neuro: Paralysis Head Injury Head Aches
 Numbness Blackouts

How were you referred to our office? Please check all that apply.

- Physician Referral & Physician Name: _____
- Hospital Affiliation & Name: _____
- Patient Referral & Name: _____
- Word Of Mouth Driving By Email
- Website Facebook Tampa Bay Surgical Arts
- Bella Medspa RealSelf Yelp
- Citysearch Vitals Healthgrades Google
- Merchant Circle Insider Pages Return 2 Fitness

Edited 3/16/2026

HIPAA Information and Consent Form

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.

What this is all about: Specifically, 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 service. 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. www.hhs.gov

We have adopted the following policies:

1. 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.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, text message, 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.
3. 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.
4. 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.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. 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 have read and understand this document

Signature of Patient or Legal Guardian

Patient Name (Please Print):

Patient Signature:

Date:

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or
Healthcare Operations

I, _____, understand that as part of my healthcare, Wayne Lee MD Plastic Surgery, originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plan for future plan for treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided a Notice of Privacy Practices that provides more completed description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carryout treatment, payment, or healthcare operations.

I understand that Wayne Lee MD Plastic Surgery PLLC is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance there on. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse treatment as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Wayne Lee MD Plastic Surgery PLLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Wayne Lee MD Plastic Surgery PLLC change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to use or disclosure of my health information:

I understand that as part of this organization’s treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

Patient Name (Please Print):

Patient Signature: _____ Date _____

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Authorization For & Release of Medical Photographs, Slides, and/or Videos

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.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

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

Consent to Take Photographs, Slides, and/or Videos

I hereby authorize Wayne Lee MD Plastic Surgery and/or his associated or licensees to take pre-operative, intra-operative, or post-operative photographs, slides, and/or videos.

Consent for Release of Photographs, Slides, and/or Videos

I hereby authorize Wayne Lee MD Plastic Surgery and/or his associate or licenses to use pre-operative, intra-operative, or post-operative photographs, slides, and/or videos for professional medical purposes deemed appropriate including but not limited to show these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, advertising purposes, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment of any other consideration as a result of any use of the images.

Patient Name (print): _____

Patient Signature: _____

Date: _____



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Medical Records Request/Release Form

Patient Name: _____

Patient DOB: _____ SSN: _____

I hereby authorize Wayne Lee MD Plastic Surgery, PLLC to Release/Request my medical Records to/from:

Name: _____

Location
Address: _____

Phone: _____ Fax: _____

Email: _____

Reason for Request: _____

Date needed: _____

Records Needed: (Please specify which medical records are needed for the above patient. For instance, Doctor's office visit notes, operative reports, prescriptions, lab work, diagnostic test results, x-rays, MRI Results, etc. Doing so will help with efficiency in processing the request. Thank you for your cooperation.)

Patient's Signature _____ Date: _____



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PLEASE SIGN ACKNOWLEDGING YOU HAVE READ AND UNDERSTAND THE PAYMENT OPTIONS AVAILABLE TO YOU AND OUR CANCELLATION POLICY

Wayne Lee MD Plastic Surgery offers 4 payment options:

- CREDIT OR DEBIT:** When paying with credit or debit card, there will be a **3.95%** convenience fee added to your total cost of services and products rendered.
Example: if your bill is \$100, **\$3.95** is added making the total charge to your credit card or debit: \$103.95. Convenience fees also count as points if your credit card offers this.
- CASH:** When paying with cash there is NO CONVENIENCE FEE applied to your total cost.
- CHECK/MONEY ORDER:** When paying with a check or money order there is NO CONVENIENCE FEE applied to your total cost.
- ACH:** Provide your bank routing and **checking** account numbers to have payment withdrawn from your account. NO CONVENIENCE FEE applied to your total cost.

Cancellation and Rescheduling Policy

We value your business and ask that you respect our business and scheduling policy. Your appointment is very important to all members of our team at Wayne Lee MD Plastic Surgery / Skin Health & Body Institute. The time allocated for the appointment is reserved especially for you. We understand that sometimes schedule adjustments are necessary; therefore, as a courtesy, we ask that you please reschedule or cancel at least 24 hours prior to the beginning of your appointment, otherwise you will be charged a cancellation fee of \$25.00.

By giving last minute notice or no notice at all, it prevents other patients from being able to schedule into that time slot.

Our policies are designed to benefit all of our patients and provide the best quality service experience for our patients.

~ Thank you for your understanding ~

Patient Printed Name

Date

Patient Signature



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I would like to know more about the following...

Surgical Procedures:

- Breast Augmentation
- Breast Reconstruction
- Mastopexy (Breast Lift)
- Gynecomastia
- BBL (Brazilian Butt Lift)
- Eyelid surgery
- Necklift
- Thigh Lift
- BodyTite, FaceTite, AccuTite (radiofrequency-assisted liposuction, face-tightening)
- Revision Augmentation
- Breast Reduction
- Abdominoplasty
- Liposuction
- Facelift
- Arm Lift
- Smartlipo
- Labiaplasty
- Other: _____

Non-Surgical Procedures:

- BOTOX
- Coolsculpting
- Skinpen
- PicoSure Pro (laser treatment to tackle age spots, freckles, brown patches, hyperpigmentation, tattoo removal)
- InMode (non-invasive and minimally invasive treatments to tone and remodel all areas of your face, neck, and body)
 - Morpheus8** (Microneedling device that utilizes radiofrequency energy to remodel & contour the face and body. Increase collagen production, diminish fine lines & wrinkles, lift, and tighten loose skin).
 - Lumeca** (IPL to treat hyperpigmentation, pigmented lesions, freckles, red scar, etc.)
 - Evolve Transform** (skin tightening, fat melting, muscle toning)
 - Forma** (RF skin tightening and reduces wrinkle for face, neck, hands)
 - Diolaze EL** (laser hair removal)
 - EmpowerRF** (vaginal rejuvenation)
 - Aviva** (non-surgical labiaplasty)
- Dermal Fillers (JUVÉDERM® ULTRA JUVÉDERM® ULTRA PLUS JUVÉDERM® VOLUMA™ XC JUVÉDERM® VOLLURE™ XC)
- Skincare (SkinMedica)
- Hydrafacial/Facials
- Other: _____