Dr. Michael A. Jazayeri Plastic & Reconstructive Surgery

Patient Information Form

_____ Do not mail information (Check if applicable)

Social Security # ---------- _____

Patient Name:_____Date: _____
(Last) (First) (M.I.)

Address: _____

(Street) (City) (State) (Zip)

Drivers License #: _____

Date of Birth:_____Age:
_____

E-Mail Address: _____

Home Phone: ( ) - Mobile Phone: ( )_____-_____

Work Phone: ( )_____-_____

****

Employer:_____Occupation: _____

Employer's Address: _____

****

Spouse: _____

Employer: _____ Occupation:_____Phone: _____

****

Person to Notify In Case of Emergency: _____

Phone Number: (_____)_____-_____

****

Responsible Person for Payment SS #:_____Date of Birth: _____

Name:_____Driver's License #: _____

Address:_____
(Street) (City) (State) (Zip)

Phone Number: (_____)_____-_____

****

How were you referred to our office?

___ Friend _Relative _Physician _Internet _Radio _Television

___ Print Ad _Other: _____

****

I hereby authorize payment of any and all insurance benefits to be paid directly to Michael Jazayeri, Inc. I understand that I am financially responsible for any changes regardless of insurance benefits and I am also responsible for any collection, legal or any other cost incurred should they be necessary on my account because of non-payment. I am aware that there will be a $25 fee for any returned payments. I hereby authorize release of any medical and or other information for the process of insurance benefits for any medical/surgical services rendered.

Signature:_____ Date: _____

Élan Institute for Plastic Surgery Medical History Questionnaire

Name: _____

_____

_____ Age:

Reason for Visit:

Allergies and Sensitivities (please circle)

Penicillin	Aspirin
Other Antibiotics	Adhesive Tape
Xylocaine	Shellfish
Codeine	Eggs

Other (list):

Medications (circle group you are currently taking)

Cortisone

Sedative, Sleeping Pills, Tranquilizers, Anti-Anxiety

Anti-Depressant Medication

Blood Pressure Medication

Medication for your Heart

Diabetic Medication

Thyroid Medication

Aspirin, Coumadin, Heparin

Birth Control Pills, Hormone Replacement Therapy

Diet Pills

Herbal/Homeopathic Plants or Medication

Other: _____

Social History (please circle)

Tobacco or Cigarettes None Socially 1 pack a day or less 2 packs a day More

Alcohol None Socially Daily

Drugs None Marijuana Cocaine Other

Surgical History

Type:_____Date: _____

_____

Type:_____Date: _____

Type:_____Date:

Did you experience any problems or complications during or following your surgery?

No _____ Yes _____ If yes, please explain: _____

Past Medical History (please list any hospitalizations below)

Purpose: _____ Date:

Date: _____

Purpose:

Date: _____

Purpose:

If female, have you ever had a mammogram? Yes No

If yes, please state most recent date and result:

Is there a family history of breast cancer in your family? Yes No

If yes, what is their relationship to you?

Review of Systems (please check)

	Yes	No		Yes	No
Skin Disease			High Blood Pressure		
Ear, Nose, Throat			Rheumatic Fever		
Thyroid			Anemia		
Palpitations			Bleeding Problems		
Diabetes Arthritis _ _ Asthma Liver Problems					
Chest Pain			Pregnant		
Shortness of Breath			Tuberculosis		
Hepatitis			HIV		

Is there any other history not noted above which the doctor should be aware of?

If yes, please explain: _____

This information is correct and true to the best of my knowledge.

Patient Signature:_____Date: _____

Date: _____

Parent/Guardian Signature:

Patient Insurance Form

Patient Name:_____Date: _____
(Last) (First) (M.I.)

Address: _____

(Street) (City) (State) (Zip)

Primary Insurance Company

Name: _____

Address: _____

(Street) (City) (State) (Zip)

Phone Number: _____

I.D. #: _____ Group #: _____

Secondary Insurance Company

Name: _____

Address: _____

(Street) (City) (State) (Zip)

Phone Number: _____

I.D. #: _____ Group #: _____

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Signature:_____Date: _____

If you do not have health insurance write, NO HEALTH INSURANCE.

_____

Patient Signature:_____Date: _____

Notice To Patients

Medical Doctors are Licensed and

Regulated

by the Medical Board of California

1-(800)-633-2322 www.mbc.ca.gov

Patient Name:_____Date: _____

Élan Institute for Plastic Surgery

Michael A. Jazayeri, M.D.

Please note there is a fee of $100 for your consultation with Dr. Jazayeri. This fee will be credited towards your surgery or procedure cost.

Patient Signature:_____Date: _____

Élan Institute for Plastic Surgery

Please circle all areas which concern you:

Aging Process

Eyelids/Bags under Eyes

Loose Skin Around Face

Loose Skin Around Neck

Wrinkles on Face

Nose

Lips

Cheeks

Ears Chin

Breasts

Abdomen

Love Handles

Back

Arms

Inner Thighs

Outer Thighs

Knees

Weight Loss

Snoring During Sleep

Other: _____

Smoking, Second-Hand Smoke Exposure, Nicotine Products (Patch, Gum, Nasal Spray)-

Patients who are currently smoking, use tobacco products, or nicotine products (patch, gum, or nasal spray) are at a greater risk for significant surgical complications of skin dying and delayed healing and additional scarring. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smoking may have a significant negative

effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication. Please indicate your current status regarding these items below:

_____ I am a non-smoker and do not use nicotine products. I understand the potential risk of second-hand smoke exposure causing surgical complications.

_____ I am a smoker or use tobacco / nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

It is important to refrain from smoking at least 6 weeks before surgery and until your physician states it is safe to return, if desired.

Patient name and signature _____

_____

Date _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individuals' home.

I wish to be contacted in the following manner (check all that apply):

□ Home Telephone_____
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only.

□ Work Telephone _____
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only

□ Written Communication
- □ O.K. to mail to my home address
- □ O.K. to mail to my work/office address
- □ O.K. to fax to this number _____

□ Other _____
_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records; P =Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; M=Mail; O=Other

(Rev. 04/04/2005)