

**Élan Institute for Plastic 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: _____

Purpose: _____ Date: _____

Purpose: _____ Date: _____

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: _____

Parent/Guardian Signature: _____ Date: _____

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: _____

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):

- | | |
|---|---|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only.

<input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> O.K. to mail to my work/office address
<input type="checkbox"/> O.K. to fax to this number _____

<input type="checkbox"/> 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

Élan Institute for Plastic Surgery

Michael A. Jazayeri, M.D.

As a courtesy to our patients, Dr. Jazayeri has waived the consultation fee for your initial visit to our office. Please note there will be a \$100 non-refundable fee for each additional consultation. The fee(s) will be used towards your procedure cost, if you decide to schedule surgery through our office.

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: _____

Print Name: _____ Date: _____