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 #: _____

I hereby authorize 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: _____

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 _____ _____