Beverly Hills Plastic Surgery Group
436 North Bedford Drive
Beverly Hills, CA 90210
(310) 275-6600

Patient's Name _____
First Middle Initial Last

Address _____
Street & Apt # City State Zip

SS# _____ Gender Male □ Marital Status □ Single
Birthdate _____ Female □ □ Married to: _____
Age _____ □ Other: _____

Home phone:_____ Can we leave a message for you at home? □ Yes □ No
Work phone:_____ Can we leave a message for you at work? □ Yes □ No
Cell phone:_____ Can we send you a text message? □ Yes □ No
Email address:_____ Can we send email to this address? □ Yes □ No

Preferred method of contact: □ Home □ Work □ Cell

Occupation: _____ Employer: _____

In case of emergency, contact: _____ Relationship to patient: _____
Home phone: _____ Work/Cell phone: _____
Reason for Visit: _____ Referral Source: _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____
Address: _____
Home phone: _____ Birth Date: _____ SS# _____

Primary Health Insurance

Name of Insurance Company: _____
Insured's Name_____ Birth date:_____ SS# _____
Insured's Employer_____ Policy ID#_____ Group# _____

Secondary Health Insurance

Name of Insurance Company: _____
Insured's Name_____ Birth date:_____ SS# _____
Insured's Employer_____ Policy ID#_____ Group# _____

All Commercial Insurance – Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Beneficiary Signature _____ Date _____

Medicare Patients Only – Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

Payment Policy

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Layke/Dr. Danielpour to bill my insurance company. I agree to pay all deductible, copay, and non-covered service amounts. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Layke/Dr. Danielpour and myself.

Signature _____ **Date** _____

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Notice of Privacy Policy

Patient's Name: _____

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may request a revised copy from the Privacy Officer.

Please list any persons (other than insurance carriers and healthcare professionals) who are authorized to receive protected health information about you:

☐ **No one**

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

By signing this form, you acknowledge your right to revoke your consent in writing except to the extent that the practice has already made disclosures in reliance upon your prior consent.

_____ _____

Patient Signature Date
(Parent/Guardian Signature if patient is under the age of 18 years)

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Patient Photography Authorization and Release

☐ I consent to the taking of photographs or videotapes of me or parts of my body, by Dr. Layke/Dr. Danielpour or his designee, in connection with my medical care or with the plastic surgery procedure(s) to be performed by Dr. Layke/Dr. Danielpour. Preoperative and postoperative photographs of my person will be used for confidential clinical record purposes only, and shall remain the property of Dr. Layke/Dr. Danielpour.

☐ I further consent to the release by Dr. Layke/Dr. Danielpour or his designated representatives of such photographs, videotapes or case histories to the appropriate insurance companies for surgical pre-authorization and/or claim review.

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as indicated by my initials below. As a result of this use I understand that these photographs, videotapes, or case information may appear in other related, updated, or reprinted formats at any concurrent or future occasion. Neither I, nor any member of my family, will be identified by name in any publication. I understand that such consent is strictly on a volunteer basis. I understand that I may refuse to sign this additional authorization and such refusal will have no effect on the medical treatment I receive from Dr. Layke/Dr. Danielpour. I understand a copy of this consent may be supplied with images to any third party wherein they may be published, or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize Dr. Layke/Dr. Danielpour to use my photographs, videotapes, and case information in the following educational or scientific settings:

- Medical journals and textbooks, scientific presentations and teaching courses in any prior, visual or electronic media, for the purpose of informing the medical profession about plastic surgery methods.
- My surgeon's office patient education materials, including pre- and postoperative photographs available only to prospective patients for viewing in the office.
- My surgeon's personal web site or web page.
- Lectures and multimedia presentations given by my surgeon for the general public.
- Television programs in which my surgeon participates.
- Newspaper or magazine articles in which my surgeon participates.
- Case studies presented on professional, society web sites.
- Photographs may be used for testing purposes by the American Board of Plastic Surgery

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that the information disclosed, or some portion thereof may be protected by state law and/or the federal Health insurance Portability and Accountability Act of 1996 (“HIPAA"').

I release and discharge Dr. Layke/Dr. Danielpour, and all parties acting under their license and authority from all rights that I may have in the photographs, videotapes or cast histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary action and certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Patient Name Date

_____ _____
Patient Signature Date
(Parent/Guardian Signature if patient under the age of 18 years)

_____ _____
Witness Date

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Medical History

Height: _____

Weight: _____

ALLERGIES ☐ Environmental allergies ☐ Latex allergies ☐ Tape allergies ☐ No known drug allergies ☐ Drug allergies:

List all DRUG ALLERGIES and type of reaction: _____

_____

MEDICATIONS.VITAMINS&SUPPLEMENTS Attach list if more than five prescription medications

Rx: _____ Dose: _____ Reason: _____

Rx: _____ Dose: _____ Reason: _____

Rx: _____ Dose: _____ Reason: _____

Rx: _____ Dose: _____ Reason: _____

Rx: _____ Dose: _____ Reason: _____

Do you use any of the following? Mark all that apply: ☐ Insulin ☐ Coumadin ☐ Home Oxygen ☐ Aspirin or ibuprofen ☐ Steroids

PERSONALPASTMEDICALHISTORY Have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Abnormal bleeding	☐	☐	Asthma	☐	☐	Attention deficit	☐	☐
Blood clots	☐	☐	Fainting spells	☐	☐	Sickle-cell disease	☐	☐
Heart attack	☐	☐	Sleep apnea	☐	☐	Birth defect	☐	☐
Coronary stents	☐	☐	Thyroid disease	☐	☐	Epilepsy/ Seizure disorder	☐	☐
Heart murmur	☐	☐	Tuberculosis	☐	☐	Anxiety disorder	☐	☐
Heart disease	☐	☐	Hepatitis	☐	☐	Cystic fibrosis	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Cerebral palsy	☐	☐
High blood pressure	☐	☐	Kidney disease	☐	☐	Cancer	☐	☐
Stroke	☐	☐	HIV/AIDS	☐	☐	Type of cancer: _____		

☐ No major illnesses or hospitalizations

☐ Other: _____

Have you been hospitalized in the past 6 months? ☐ No ☐ Yes: _____

Are your immunizations current? ☐ Yes ☐ No ☐ Unsure

Do you wear any of the following? (Mark all that apply.) ☐ Contact lenses ☐ Eye glasses ☐ Hearing aid(s) ☐ Dentures ☐ Orthodontics/braces ☐ Limb prosthesis or brace: _____

PASTSURGERIES ☐ No previous surgeries

Date: Type: Hospital: Surgeon:

_____

_____

_____

Have you ever had a transfusion? ☐ No ☐ Yes – When: _____

Have you had complications or bad reactions to anesthesia? Mark all that apply:

☐ No past anesthesia problems ☐ Never received general anesthesia ☐ Difficult intubation ☐ Difficult extubation

☐ Malignant hyperthermia ☐ Post op nausea/vomiting ☐ Local anesthetic resistance ☐ Allergic reaction

☐ Difficulty waking up ☐ Sensitivity to anesthesia agent

Medical History (Page 2)

WOMEN ONLY

Are you currently pregnant? ☐ Yes ☐ No ☐ Maybe

Number of pregnancies:_____ Number of natural children: _____ Did you breast feed? ☐ Yes ☐ No

Number of adopted children: _____ Last menstrual period: _____ Date of last mammogram: _____

Have you had your tubes tied? ☐ Yes ☐ No Have you had a hysterectomy? ☐ Yes ☐ No

FAMILYHISTORY Have any blood relatives ever had any of the following?

	Yes	No		Yes	No		Yes	No
Breast cancer	☐	☐	Tuberculosis	☐	☐	Birth defects	☐	☐
Heart disease	☐	☐	Cleft lip or palate	☐	☐	AIDS/HIV	☐	☐
Diabetes	☐	☐	Epilepsy	☐	☐	Cystic fibrosis	☐	☐
Abnormal bleeding	☐	☐	Kidney disease	☐	☐	Melanoma	☐	☐
Mental illness/ bipolar	☐	☐	Blood clots	☐	☐	High blood pressure	☐	☐
Sickle cell disease/trait	☐	☐	Mental delay/retardation	☐	☐	Stroke	☐	☐
List any other serious illness not listed here:_____						Anesthesia problems	☐	☐

☐ Adopted or family history unknown

SOCIALHISTORY: ADULT PATIENTS ONLY

Gender:_____ Occupation:_____ Marital Status:_____ Name of Significant Other:_____ Hobbies:_____

Is a responsible adult available to assist during surgery recovery period? ☐ Yes ☐ No

Do you smoke? ☐ No ☐ Yes – Cigarettes Cigars Pipes Marijuana How much? _____packs/day or packs/week

Have you ever smoked? ☐ No ☐ Yes – Number of years smoked_____ Date quit: _____

Are you aware that smoking increases the risk for surgical complications? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes – How much? _____drinks ☐ Daily ☐ 2-3 x per week ☐ Weekly ☐ Occasionally

Do you have a history of drinking to excess? ☐ No ☐ Yes – Date quit: _____

Do you use any recreational drugs? ☐ No ☐ Yes – List: _____

Medical History (Page 3)

REVIEWOFSYSTEMS Please mark if you have any of the following:

General Symptoms: ☐ Fatigue ☐ Sleep difficulties ☐ Unexplained fevers ☐ Loss of appetite ☐ Unexplained weight loss ☐ Recent weight gain

Skin: ☐ Color changes ☐ Previous skin cancer ☐ Birthmark ☐ Hair loss ☐ Excessive sweating ☐ Stretch marks

Ears, Nose and Mouth:

☐ Hearing loss	☐ Poor eyesight	☐ Nasal obstruction	☐ Speech problems
☐ Dizziness	☐ Eye pain	☐ Nosebleeds	☐ Crowded teeth
☐ Ringing in ears	☐ Sinus infections	☐ Cold sores	☐ Bleeding gums
☐ Ear infections	☐ Broken nose	☐ Hoarseness	☐ Toothache

Breast:

☐ Breast pain	☐ Lumps	☐ Nipple discharge	☐ Dimpling
☐ Previous biopsy	☐ Specialty bras	☐ Breast implants	☐ Change in size

Lung:

☐ Chronic cough	☐ Pain with deep breathing		☐ Bloody sputum
☐ Recent infection	☐ Asthma	☐ Pneumonia	☐ Shortness of breath

Heart:

☐ Chest pain	☐ Palpitations	☐ Heart defect
☐ Abnormal stress test	☐ Lightheadedness/syncope	☐ Arrhythmias

Gastrointestinal:

☐ Abdominal pain	☐ Problems swallowing	☐ Abnormal stool	☐ Nausea/vomiting
☐ Chronic constipation	☐ Jaundice/liver problems	☐ Abdominal swelling	☐ Abdominal masses
☐ Acid reflux	☐ Hernias	☐ Intestinal colic	☐ Diarrhea

Genital/urinary:

☐ Difficulty voiding	☐ Frequent urination	☐ Incontinence	☐ Kidney stones
☐ Bladder infections	☐ Kidney infections	☐ Abnormal menstrual periods	☐ STD

Musculoskeletal:

☐ Neck mobility problems	☐ Joint pains	☐ Weakness	☐ Chronic back pain
☐ Shoulder grooving/pain	☐ Scoliosis	☐ Torticollis	☐ Muscular dystrophy

Neurological:

☐ Headaches	☐ Migraines	☐ Previous concussion	☐ Convulsions
☐ Numbness	☐ Gait difficulties	☐ Memory problems	☐ Tremors

Psychological:

☐ Depression	☐ Anxiety	☐ Psychiatric illness	☐ Bipolar disorder
☐ Delayed milestones	☐ ADD/ADHD	☐ Learning disabilities	☐ Behavioral issues

Hematology/Oncology: ☐ History of cancer ☐ Radiation Therapy ☐ Chemotherapy ☐ Easy bruisability

Referral information: ☐ Friend_____ ☐ Hospital_____ ☐ Doctor_____

☐ Family_____ ☐ Previous Patient_____ ☐ Ad/voucher_____

☐ Internet_____ ☐ Other_____

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