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

Birthdate: _____ **Gender**: Female ○ **Marital Status**: □ Single
Age: _____ Male ○ □ Married to: _____
□ Other: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____
Occupation: _____
Employer: _____

Referral Source (Please Circle or Write Where Indicated):

Real Self ☐ **Yelp** ☐ **Google** ☐ **Television** ☐

Friend: _____ **Social Media:** _____

Physician: _____ **Other:** _____

In case of emergency, contact: _____ Relationship to patient: _____

Home Phone: _____ Work/Cell phone: _____

Reason for Visit: _____

Primary Health Insurance

Name of Insurance Company: _____

Insured's Name: _____ Birth Date: _____ SS#: _____

Insured's Employer: _____ Policy ID: _____ Group#: _____

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:** _____

Notice of Privacy Policy

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:

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 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.

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

Patient Signature: _____ Date: _____

Patient Photography Authorization and Release

Please check-mark where indicated:

☐ 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 consent to the use of my photographs and videotapes for the Beverly Hills Plastic Surgery Group website

☐ I consent to the use of my photographs and videotapes for social media purposes.

☐ I do *not* consent to any photos that are not specifically for confidential clinical purposes only

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 (Parent/Guardian Signature if patient under the age of 18 years):

_____ Date: _____

Witness: _____ Date: _____

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

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

PERSONAL PAST MEDICAL HISTORY **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: _____

PAST SURGERIES ☐ 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

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

Medical History (continued…)

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	☐	☐
						Anesthesia problems	☐	☐

List any other serious illness not listed here:_____

☐ 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: _____

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

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

BOTOX (Botulinum A Toxin) and DERMAL FILLERS CONSENT

Patient Name: _____

To the patient: You have the right to be informed about your treatment so that you may decide to undergo the procedure, knowing the risks and hazards involved.

I, _____, have received a consultation and I consent to having Botox and/or Dermal Fillers carried out upon me.

I have been informed about the treatment, procedure, indication, expected results and possible side effects. I understand that I may experience swelling, redness, tenderness, slight headache, pain and/or bruising that may occur for several days after my treatment, however these symptoms will resolve. Rarely, an adjacent muscle may be weakened for several weeks after injections. I have been advised of the risks involved and the expected benefits of Botox and/or Dermal Filler.

I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons and that no guarantees can be made as to the exact results of this procedure. I understand that while every precaution will be taken to prevent complications and that while complications from this procedure are rare, they can and sometimes do occur.

I accept responsibility for any complications that may occur and thereby absolve Beverly Hills Plastic Surgery Group and any associated person(s) of any blame resulting there from.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

_____	_____	_____
Patient Signature	Date	Witness

I do not consent to the use of Botox and/or Dermal Fillers now or in the future: _____

Patient Signature/ Date