



Andre Aboolian, MD, FACS
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PATIENT INFORMATION FORM

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

_____ Gender: _____

Social Security Number: _____ Marital Status: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

Who referred you (how did you hear about Dr. Aboolian)? _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: Spouse Parent/Guardian Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance (skip if cosmetic or self pay)

Name: _____ Policy #: _____ Group ID: _____

Policy Holder's Name: _____ SSN #: _____ Insured's DOB: _____

Assignment and Release

I, _____, have insurance coverage and assign directly to Dr. Aboolian all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Physician, MSSG and/or all representatives there of to release all information necessary to secure the payment of benefits and to file an appeal and seek claim status information. I authorize the use of this signature on all my insurance submissions.

Signature of Insured / Guardian

Date

Patient Name: Heather TEST

Date of Birth: 1/28/1986

Procedures or Products of Interest

Body:

- Liposuction / Lipocontouring
- Body contouring after major weight loss
- Tummy tuck
- Buttock lift
- Thigh lift
- Buttock enlargement (Brazilian Butt Lift)
- Correction of tummy tuck or liposuction
- Arm lift
- Body lift
- Hernia repair
- Labia repair
- Other:

Breast:

- Breast enlargement
- Breast implant revision
- Breast reduction
- Breast lift
- Breast lift with enlargement
- Nipple reduction
- Correction of inverted nipples
- Male chest reduction

Face:

- Nose surgery
- Breathing problems
- Eyelid lift
- Brow lift
- Face lift
- Ear pinning
- Neck lift or liposuction
- Chin enlargement
- Buccal fat removal

In Office:

- Botox
- Juvederm
- Latisse
- Skin care
- Scar revision
- Mole removal

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? No Yes, please describe:

2. Do you have a blood relative who had anesthesia complications of any kind? No Yes, please describe:

Section II: Specific Medical History

1. Are you pregnant? No Yes

Height: _____

Weight: _____

Have you or do you still have:

	No	Yes	Description
2. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Hepatitis or Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Problem Scarring	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Have you been advised to or had psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Others Not Listed:			_____

Section III: Medications

Are you taking or have you taken in the past:

	No	Yes	Description
1. Medication for blood pressure or water pills?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Antidepressants, tranquilizers or sedatives?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Blood thinners including Motrin, Advil or Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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- 4. Steroids? _____
- 5. Diabetic Medication? _____
- 6. Seizures _____
- 7. Heart Medications? _____
- 8. Other Medications: _____

Medications that cause bleeding: Do you take any of the following on a regular basis:

	No	Yes	Description
1. Aspirin or aspirin containing medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Ibuprofen (Motrin, Advil & Nurpin)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Ketoprofen (Alleve)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Vitamin E (excluding that in a multivitamin)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Anti-inflammatories or muscle relaxants?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Section IV: Allergies and Sensitivities

Is there any history of skin reaction or other illness following contact with:

	No	Yes	Description
1. Penicillin, Sulfa or other antibiotic?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Morphine, Codine, Demerol or narcotic?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Novocain, Lidocaine or local anesthetics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Tetanus toxoid or serums?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Adhesive tape?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Iodine, Betadine, Chlorhexidine or Phisophex?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Tincture or Benzoin?	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Latex rubber?	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Other drug medicine of other substance?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Consent to Communicate

Method		
<input type="checkbox"/> Call Work Phone	<input type="checkbox"/> Call Cell Phone	<input type="checkbox"/> Call Home Phone
<input type="checkbox"/> Email	<input type="checkbox"/> Email Appt Reminders	<input type="checkbox"/> Email Communication Info
<input type="checkbox"/> Send Text Page – if so, list cell carrier: _____		

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Signature: _____

Date: _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

NOTICE TO OUR PATIENTS:

Title 16, California Code of Regulations section 1355.4, requires us to inform you that Andre Aboolian, MD, FACS is licensed and regulated by the Medical Board of California. Information requests may be obtained or complaints reported to:

Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

I have read and understood the above HIPPA and california code of regulation.

Signature: _____

Date: _____

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Date of Birth: 1/28/1986