ANNE PELED, MD

COSMETIC HISTORY FORM

IF THIS IS YOUR FIRST VISIT, PLEASE TAKE THE TIME TO FILL THIS FORM OUT COMPLETELY.

Patient Name: _____ Age: _____ Date of Birth: _____ Weight: _____ Height:_____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-mail address: _____
Emergency Contact Name: _____
Emergency Contact Cell Phone: _____ Emergency Contact relationship to you _____
Reason for today's visit: _____
How did you hear about us? _____

Are there specific health issues, procedures or products of interest to you? (Please check all that apply)

- ❑ Nose re-shaping (rhinoplasty)
- ❑ Tummy tuck (abdominoplasty)
- ❑ Liposuction
- ❑ Facelift
- ❑ Prominent ears (otoplasty)
- ❑ Arm lift (brachioplasty)
- ❑ Male breast reduction
- ❑ Thigh lift
- ❑ Eyebrow lift
- ❑ Breast augmentation/lift/reduction
- ❑ Eye rejuvenation (blepharoplasty)
- ❑ Skin Care Advice
- ❑ Sunscreen Advice
- ❑ Skin Rejuvenation
- ❑ Birthmarks/Moles/Scarring
- ❑ BOTOX Cosmetic™ or Dysport™ (i.e. Botulinum Toxin Type A)
- ❑ Injectable fillers (e.g. Juvederm™, Radiesse™, Restylane™, Perlane™)
- ❑ Other, please specify_____
  _____

PAYMENT OPTIONS:

- MasterCard & Visa are accepted
- Personal checks are accepted at least 14 days prior to surgery

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Do you **currently** have any of the following conditions?

	YES	NO
EYES		
NONE	❑	
Cataract(s)	❑	❑
Visual disturbance(s)	❑	❑
Glaucoma	❑	❑
Retinal problems	❑	❑
EAR, NOSE, THROAT		
NONE	❑	
Sore throat	❑	❑
Chronic sinus drainage	❑	❑
Nasal breathing issues	❑	❑
RESPIRATORY		
NONE	❑	
Use oxygen at home	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
GASTROINTESTINAL		
NONE	❑	
Chronic nausea	❑	❑
Abdominal pain	❑	❑
Diarrhea	❑	❑
Hepatitis	❑	❑
Gall stones	❑	❑
Hernia(s)	❑	❑
Spleen problems	❑	❑

	YES	NO
ENDOCRINE		
NONE	❑	
Insulin dependent diabetes	❑	❑
Diabetes controlled with pills	❑	❑
Diabetes controlled with diet	❑	❑
Thyroid disease	❑	❑
Parathyroid disease	❑	❑
CARDIAC		
NONE	❑	
Heart attack	❑	❑
Angina	❑	❑
Heart failure	❑	❑
Hypertension	❑	❑
Pacemaker	❑	❑
Cardiac bypass	❑	❑
Cardiac catheterization	❑	❑
Angioplasty	❑	❑
High cholesterol	❑	❑
HEME/LYMPH		
NONE	❑	
Lymph node swelling	❑	❑
Bleeding problems	❑	❑

	YES	NO
GENITOURINARY		
NONE	❑	
Pain w/ urination	❑	❑
Kidney/bladder infection	❑	❑
Kidney stone(s)	❑	❑
Blood in urine	❑	❑
Uterine fibroids	❑	❑
MUSCOLOSKELETAL		
NONE	❑	
Joint Pain/Swelling	❑	❑
Herniated disk	❑	❑
Arthritis	❑	❑
Back pain	❑	❑
NEUROLOGIC		
NONE	❑	
Stroke	❑	❑
Migraines	❑	❑
Neuropathy	❑	❑
SKIN		
NONE	❑	
Moles	❑	❑
Skin cancer	❑	❑

PAST MEDICAL HISTORY:

Have you **ever** had any of the following?

Anemia	❑ Yes	❑ No	Heart murmur	❑ Yes	❑ No	Mitral valve prolapse	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Rheumatic fever	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Skin cancer	❑ Yes	❑ No
Bleeding problem	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Blood transfusion	❑ Yes	❑ No	High blood pressure	❑ Yes	❑ No	Thyroid disease	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No	Seizures	❑ Yes	❑ No
Heart disease	❑ Yes	❑ No	Kidney disease	❑ Yes	❑ No			

If yes to any of the above, please describe the condition: _____

_____

_____

PAST SURGICAL HISTORY (including cosmetic surgery):

Please list any previous surgery with approximate dates:

Procedure	Date	Procedure	Date

FAMILY HISTORY:

Do you have **family members** with any of the following conditions:

Breast Cancer	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No
Other Cancer	❑ Yes	❑ No	Stroke	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No
Bleeding Issues	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Depression	❑ Yes	❑ No

If yes to any of the above, please describe the condition and identify your relation to the family member:

_____

_____

_____

MEDICATIONS:

Please list any prescription, non-prescription, and herbal medications you are taking along with doses. If you have a long list, please bring it to us.

☐ NONE _____ _____ _____ _____

_____ _____ _____ _____

DRUG ALLERGIES: _____ ☐ NONE

SOCIAL HISTORY:

Marital Status: _____ Spouse/Partner's name _____

Are you currently employed? yes ___ no ___ If so, what do you do? _____

Do you smoke? yes ___ no ___ If so, how many packs per day? _____

If you smoked in the past, when did you quit? _____

On average, how many alcoholic drinks do you have per week? _____

Insurance Information:

Primary Insurance:_____ Policy Holder:_____

Physician Information:

Primary Care Physician: _____ City/State_____

OFFICE & INSURANCE BILLING AUTHORIZATION AND NOTIFICATION

By my signature below, I am authorizing ANNE PELED, MD to bill my insurance company for services provided if applicable. Occasionally, insurance companies send the insured party (yourself) reimbursement directly for medical services provided by their doctors. In such an event, any monies received directly by me for services rendered by Dr. Peled will be forwarded to this office within 2 weeks of receipt. In addition, any co-pays or deductibles will be paid in full within 2 weeks of any procedure or office visit as applicable. Finally, I understand that Dr. Peled may or may not be a participating provider with my insurance plan. As such, the allowed amount according to my insurance company for any services/procedures rendered may be less than the amount charged by ANNE PELED, MD and I acknowledge that the difference will be my responsibility. I further acknowledge that any questions regarding these matters have been answered by Dr. Peled and/or her staff.

_____
Printed Name

_____ _____
Signature Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

_____
Relationship

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have been presented with a copy of Anne Peled, MD's 'Notice of Privacy Practices' (ask Alexandra for a paper copy; they are also available online at all times at this address: http://www.annepeledmd.com/forms.html), detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of these 'Practices', and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

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

_____
Printed Name

_____ _____
Signature Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

_____
Relationship

PHOTOGRAPHIC CONSENT

I hereby grant permission for the use of any of my photographic medical records including illustrations, images, and/or other imaging records to Dr. Anne Peled for the following uses:

** All identifiable characteristics will be omitted to protect patient privacy unless written consent is obtained from the patient. **

Educational presentations/lectures to other physicians _____	☐ Yes	☐ No
Discussions with other patients about potential surgery outcomes	☐ Yes	☐ No
Inclusion on practice website to show potential surgery outcomes	☐ Yes	☐ No

I also understand that I may withdraw this permission or limit it at any time by giving Dr. Peled written notice specifying the images I no longer want her to use (or that I do not want any of my images used). Dr. Peled will discontinue use of the designated images within 15 business days of receiving the written notice.

_____
Patient Signature

_____
Print Name

_____
Date