

PATIENT INFORMATION

PERSONAL:

Full Name: _____

Address: _____

City/State: _____

Zip: _____

Date of Birth: _____

Social Security No.: _____

Phone: (Home) _____

(Work) _____

(Cell) _____

CONTACT:

May we inform you of new products or special Discounts through e-mail? **YES / NO**

E-mail address: _____

Emergency contact? _____

Phone: _____ Relation: _____

Which phone number do you prefer that we call? _____

May we leave a message? **YES / NO**

PRIMARY DOCTOR:

Name: _____

Address: _____

REFERRAL INFORMATION:

How were you referred to us?

(circle all that apply)

Doctor: _____

Newspaper: _____

Yellow Pages: Verizon Transwestern

Community Little Book

Friend: _____

Radio

Website

Other: _____

INSURANCE INFORMATION:

Primary Coverage: _____

Subscriber's Name: _____

Identification Number: _____

Effective Date: _____

Secondary Coverage: _____

Subscriber's Name: _____

Subscriber's SSN: _____

Identification No.: _____

Group Number: _____

Effective Date: _____

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance companies and will credit any such collections to the patient's account.

PAYMENT AUTHORIZATION

I, _____, hereby authorize Richard V. Balikian, MD to furnish information concerning my present illness. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photostatic copy of this authorization will be as valid as the original.

Signature of Patient: _____

Date: _____

BALIKIAN FACIAL PLASTIC SURGERY
A MEDICAL CORPORATION
SPECIALIZING IN FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

PATIENT HISTORY

Name: _____ DOB: _____ Date: _____

Describe the reason for today's visit: _____

PAST MEDICAL HISTORY: (Please check box if you have ever had:)

- | | |
|---|--|
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Headaches _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Heart attack _____ |
| <input type="checkbox"/> Bleeding disorders _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Blood clots in legs or lungs _____ | <input type="checkbox"/> High blood pressure _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> HIV/AIDS _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Reflux/Heartburn _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Thyroid problems: _____ |
| <input type="checkbox"/> Environmental allergies _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Other: _____ |

PAST SURGICAL HISTORY: (Please list any and all previous surgeries)

ALLERGIES: (Please list any medication allergies)

LATEX ALLERGY? YES / NO

MEDICATIONS: (Please list all current medications and doses)

SOCIAL HISTORY:

Do you smoke? (please circle)	Yes	No
Do you regularly drink alcohol?	Yes	No
Any recreational drug use?	Yes	No

Present occupation: _____

Packs per day: _____ For how many years? _____
How many glasses of wine or cans of beer per week? _____
Type of drug(s): _____

FAMILY HISTORY: (Please check box if any of your immediate family members have any of the following)

- | | |
|--|---|
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Bleeding problems _____ |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Ear/hearing problems _____ |

REVIEW OF SYSTEMS: (Please circle any of these symptoms that you have had within the past 6 months)

General: weight loss, night sweats, poor appetite, lethargy, dizziness/vertigo
Head/Neck: headaches, vision changes, difficulty swallowing, painful swallowing, facial weakness
Heart: chest pain, rapid heartbeat, shortness of breath
Respiratory: productive cough, dry cough, bloody cough, nosebleeds, nasal blockage
Digestive: nausea, vomiting, diarrhea, bloody stools, constipation
Urinary: painful urination, blood in urine, frequent urination



GENERAL CONSENT

Patient Name: _____

1. *Consent.* I authorize and consent to examination and treatment of the person named above as a patient at Balikian Facial Plastic Surgery. I understand that staff members, trainees, residents, and supervised health care profession students may participate in patient care under supervision of the physician.
2. *Information and questions:* I understand that no assurances can be made concerning the results or outcome of any examination or treatment. I recognize that no explanation or treatment can be exhaustive, and that there may be other risks and complications. I have had an opportunity to ask questions, and questions have been answered to my satisfaction. I may request more detailed information or explanations at any time.
3. *Refusal:* I understand that I may refuse or revoke consent to any recommended examination, procedure or treatment at any time, to the extent permitted by law. It is my responsibility to clearly communicate refusal of consent to the physician, or to other Balikian Facial Plastic Surgery personnel responsible for patient care.
4. *Specimens.* Any body fluids, organs or other body parts or tissues removed during the course of examination or treatment may be disposed of, retained, or used for any lawful purpose by Balikian Facial Plastic Surgery.
5. *Release of information:* I authorize Balikian Facial Plastic Surgery and its staff to release medical and financial information concerning the patient's examination and treatment that may be reasonably necessary in order to obtain payment for services rendered, or to review or evaluate patient care.
6. *Release for valuables:* I release Balikian Facial Plastic Surgery from any responsibility for patient valuables, money, or other personal property or possessions. I also release Balikian Facial Plastic Surgery from any responsibility for loss or damage to any article, including jewelry, which must be removed to carry out any procedure, and for any article not claimed from safekeeping by or for the patient within sixty days after discharge or departure from Balikian Facial Plastic Surgery premises.
7. *Acknowledgement.* I have read this Consent, or it has been read to me, and I understand what it means. I certify that: (check one)
 _____ *I am the patient, and I am either 18 years of age or older, or married, or the parent of a child.*
 _____ *I am the minor patient's parent or legal guardian.*
 _____ *I am the incapacitated adult patient's legal guardian or Health Care Agent (a copy of the Health Care Proxy must be provided).*
 _____ My basis for consenting on the patient's behalf is: _____
8. *Notice of Privacy Practices:* I have received, read, and understand a copy of the Notice of Privacy Practices as defined under federal law (Health Information Privacy and Accountability Act, HIPAA) describing how Balikian Facial Plastic Surgery may protect and use my health information.
9. *Proposition 65:* According to California state law Proposition 65, I am aware that this building may contain chemicals known to the State of California to cause cancer, birth defects, or reproductive disorders.

Patient or Authorized Representative:

Witness:

Signature

Signature

Print name

Print name

Relationship to patient: _____

Title: _____

Telephone number: _____

Date: _____