

ATLANTIC CENTER FOR PLASTIC & COSMETIC SURGERY

(770) 418-1234

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name

First

Middle

Last

Address _____

Street & Apt #

City

State

Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____

Contact Restrictions: _____

Age _____ Birthdate _____ SS# _____ Gender Female Male

Marital Status Single Married to: _____ Other: _____

Patient's Employer

_____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____

Street & Suite #

City

State

Zip

How did you hear about Dr. Davoudi?

(Mark all that apply)

TV News TV Ad Phone Book Magazine Newsletter Seminar Salon Web

Friend/Relative: _____ Doctor: _____ Other: _____

If you were referred by a specific person, may we thank them? Yes No

Emergency Contact

(Not in your household)

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Insured: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered, and the cosmetic surgery deposit of \$500.00, due at the time surgery is scheduled, is a non-refundable deposit. I authorize Dr. Davoudi to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Davoudi and myself.

Signature _____

Date _____

Areas of Interest:

Facial Procedures

- Blepharoplasty (Eyelid Lift)
- Botox
- Brow or Forehead Lift
- Earlobe Repair
- Facial Liposuction (Neck, Jowls)
- Face or Neck Lift
- Lip Enhancement
- Otoplasty (Ear Pinning)
- Rhinoplasty (Nose Reshaping)
- Skin Resurfacing (Laser, Peel, Etc.)
- Wrinkle Fillers (Injections)

Breast Procedures

- Breast Augmentation
- Breast Reconstruction
- Breast Reduction
- Mastopexy (Breast Lift)
- Nipple Reduction or Inversion

Body Procedures

- Abdominoplasty (Tummy Tuck)
- Brachioplasty (Arm Lift)
- Full Body Lift
- Liposuction (Thighs, Abdomen, Etc.)
- Thigh or Buttock Lift
- Fat Transfer

Other Procedures

- Skin Care
- Laser Hair Removal
- Lesions / Moles

ATLANTIC CENTER FOR PLASTIC & COSMETIC SURGERY (770) 418-1234

Health Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____ Reason for Visit: _____

Age: _____ Height: _____ Feet _____ Inches Weight: _____ Lbs.

Current Physician(s): _____

List all Surgeries (Hospitalization and the Date of Occurrence):								
List any Serious Illnesses and/or Accidents:								
Do you have or have you had any of the following: (circle for each, give date occurred if Yes)								
Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Problems / Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetics	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes			
Ear Infection	No	Yes	High Blood Pressure	No	Yes			
Do you smoke?	No	Yes	If yes, how much?	_____	Pack(s)/day	How long?	_____	Years
Do you drink alcohol?	No	Yes	If yes, how much?	_____		How often?	_____	
Do you use recreational drugs?	No	Yes	If yes, describe:	_____				
Do you have bleeding or bruising problems?	No	Yes	If yes, describe:	_____				
Do you have problems with scarring?	No	Yes	If yes, describe:	_____				
Do you have any history of problems with anesthesia?	No	Yes	If yes, describe:	_____				
List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.								
List ALL drug and/or latex allergies.								

The above information is accurate and complete to the best of my knowledge.

Signature _____ Date _____

Atlantic Center for Plastic and Cosmetic Surgery
PATIENT ACKNOWLEDGMENT FORM

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 obtain a revised copy.

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.

Name

Date