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. I understand any unpaid balance that is turned over to collections is subject to a $50.00 service charge and 38% collection fee.

Signature _____ **Date** _____

Areas of Interest:

Facial Procedures

- ❒ Blepharoplasty (Eyelid Lift)
- ❒ Botox
- ❒ Brow or Forehead Lift
- ❒ Chin Augmentation
- ❒ 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
- ❒ Gynecomastia – Male Breast Reduction
- ❒ Mastopexy (Breast Lift)
- ❒ Nipple Reduction or Inversion

Body Procedures

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

Other Procedures

- ❒ Skin Care
- ❒ Laser Hair Removal
- ❒ Lesions / Moles

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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

HIPPA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself please complete the following:

I authorize Atlantic Center for Plastic & Cosmetic Surgery to leave medical information pertaining to my care by the following methods and will assume responsibilty to notify them, in writing, whenever this information changes.

Home telephone	**yes____ no____**	**Voice mail**	**yes____ no____**
Answering machine	**yes____ no____**	**Cellphone/voice mail**	**yes____ no____**
Work phone	**yes____ no____**	**Pager**	**yes____ no____**

May we fax medical records for referrals? yes____ no____

Please list names of people we can discuss your medical or skin care with:
Spouse Name_____ yes____ no____
Parent Name_____ yes____ no____
Other Name_____ yes____ no____
Please give name and relationship such as boyfriend, sister, etc.

Please list a "unique identifier" as a way to confirm your identity when calling the office. This "unique identifier" must be given before any information can be disclosed.

Unique Identifier:_____
(last four digits of your social security number or mother's maiden last name)

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 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.

_____ _____
Signature of Patient/Guardian **Date**