

Date: _____

**RAMIN A. BEHMAND, MD, FACS
VIVIAN TING, MD, FACS**

Patient's Personal Information:

Social Security Number: _____ - _____ - _____ Age: _____ Date of Birth: _____

Patient Name: _____

Miss Mrs. Ms. Mr. Dr.
Single Married Divorced Separated Widowed

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

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Email: _____

Patient's Occupation: _____ Employer: _____

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

Spouse's Name: _____ Spouse's Occupation: _____

Spouse's Employer: _____ Spouse's Work Phone: (____) _____

Family Doctor/Internist: _____ Address: _____ Phone: _____

Patient's Insurance Information:

Insurance Company: _____ Group No. _____ Policy No. _____

Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Social Security No. of Policy Holder: _____ - _____ - _____

Person Financially Responsible: Patient Parent Other Responsible Party's DOB: _____

Name of Financially Responsible Party: _____ Relationship to patient: _____

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

Occupation: _____ Employer: _____

Business Phone: (____) _____ City: _____ State: _____ Zip: _____

** Emergency Contact Person: _____ Phone Numbers: _____

Patient's Referral Information:

How did you learn about us: _____

Assignment & Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with (name of insurance company) _____ and assign directly to Ramin A. Behmand, M.D./Dr. Vivian Ting, M.D. insurance 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 doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature, original or photocopy, on all insurance submissions.

X _____ Date: _____
Responsible Party Signature

Medical History Information

Patient Name: _____

Present Problem

Specific problem for which you are seeking plastic surgery: _____

Have you consulted any other doctors, including plastic surgeons about this? No _____ Yes _____

If yes, please list their names _____

Past Medical History

General Health: Good Fair Poor

If not good, please explain: _____

Height: _____ Weight: _____ Weight Loss or gain in the past year _____ lbs: Loss Gain

How long ago did you have a physical check up? _____

Did it include an electrocardiogram (EKG)? Yes _____ No _____ Chest X-Ray? Yes _____ No _____

Name and address of Doctor: _____

(Name)

(Address)

Previous/Current Illness (Please list):

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Past Surgical History (Please List)

Operation	Year	Surgeon	Operation	Year	Surgeon
1. _____			5. _____		
2. _____			6. _____		
3. _____			7. _____		
4. _____			8. _____		

Have you had any significant complications or after effects from these operations? No _____ Yes _____

If yes, Please explain:

Injuries (Please List):

	Type	Year	Status (resolved vs. ongoing)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Family History

	Age	State of Health
Mother:	_____	_____
Father:	_____	_____
Brother(s):	_____	_____
Sister(s):	_____	_____
Children:	_____	_____

Has anyone in your family had (check all that apply): Tuberculosis, Cancer, Diabetes, Epilepsy, Heart Disease, High Blood Pressure, Lung Disease, Kidney Disease, Bleeding Disorders, Asthma, Mental disease

Medications (Please List All, Including Herbal)

Medication	Dosage	Medication	Dosage
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

Social History

What is your approximate daily consumption of the following?

Coffee or Tea _____

Tobacco _____

Alcohol _____

Number of smoking years? _____

Type of Alcoholic Beverage _____

Allergies (Please List)

Medications: _____

Other: _____

** Check if no known allergies to medications (NKDA): _____

Are you allergic to adhesive tape? _____

Pertinent Health Information

- | | | |
|---|--|------------------------------------|
| 1. Have you ever had a reaction to a local anesthetic (Novocain, etc)? | No | Yes |
| If yes, which anesthetic(s)? _____ | | |
| 2. Have you or a member of your family ever had a reaction to general anesthesia? | No | Yes |
| 3. Do you have high blood pressure? | No | Yes |
| 4. Do you or any member of your family have diabetes? | No | Yes |
| If yes, who? _____ | | |
| 5. Have you ever had either Scarlet or Rheumatic Fever? | No | Yes |
| 6. Do you bruise easily? | No | Yes |
| 7. Do you bleed easily (from cuts, previous surgery, and tooth extractions)? | No | Yes |
| 8. Are you a slow or poor healer? | No | Yes |
| 9. Do you form large scars or keloids? | No | Yes |
| 10. Do you have any skin diseases, hives, eczema, or rash? | No | Yes |
| 11. Are you, or have you, taken steroid medications, cortisone or ACTH ? | No | Yes |
| 12. Do you have shortness of breath with walking? | No | Yes |
| 13. Does your religion prohibit blood transfusions? | No | Yes |
| 14. Do you or have you ever had emotional difficulties requiring psychiatric attention? | No | Yes |
| 15. Have you had any illness or disorders of the following? (Circle if yes) | | |
| BRAIN (strokes, epilepsy) | FACE (paralysis) | LUNGS (asthma, COPD) INTESTINES |
| BONES or JOINTS | EYES (cataract, glaucoma, and dryness) | BLOOD |
| NOSE, THROAT, SINUS | HEART, BLOOD VESSELS | LIVER ARMS or LEGS |
| EARS | BREASTS | STOMACH URINARY SYSTEM |
| NERVOUS SYSTEM | ENDOCRINE OR DIABETES | REPRODUCTIVE SYSTEM |

If circled, please explain: _____

Signature: X _____

Relationship to patient (if other than patient): _____