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 _____ Number of smoking years? _____

Alcohol _____ 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): _____