AZAR PLASTIC SURGERY & MED SPA

425 Haaland Drive Suite 200 • Thousand Oaks CA 91361

Last Name _____ First Name _____ Date _____

Date of Birth _____ Age _____ Height _____ Weight _____ Sex: M ❑ F ❑

Street Address _____ City _____ State _____ Zip _____

Email Address _____

Preferred Method of Contact
Cell ❑ Home ❑ Work ❑

Cell Phone Number _____ Home Phone Number _____ Work Phone Number _____

Emergency Contact Person _____ Relationship to you _____

Phone _____ Alternate Phone _____

Race ❑ Caucasian ❑ Hispanic or Latino ❑ Pacific Islander ❑ Other

Ethnicity _____ Preferred Language _____

Employment Status ❑ Full-Time ❑ Part-Time ❑ Unemployed

Relationship Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed/ Separated

Employer _____ Occupation _____

Other Family Seen Here _____

How did you hear about Azar Plastic Surgery? _____

Patient/Guardian Signature _____ Date _____

Azar
Plastic Surgery & Med Spa

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MEDICAL HISTORY

Name _____ Age _____ Date _____

Primary Care Physician _____

Reason for Consultation _____

Health Problems/Conditions _____

Operations (Including cosmetic & pregnancy)

Type	Date	Complications

Medications (Including vitamins & herbal supplements):

Type	Dosage Amount	Frequency

Allergies (Food & medication) No ❑ Yes ❑ _____ provide details

Tobacco Use No ❑ Yes ❑ How many times per day? _____

Alcohol Use No ❑ Yes ❑ ❑ 1-3 a week ❑ Socially ❑ Never ❑ Daily

Illegal Drug Use No ❑ Yes ❑

Are you pregnant or possibly pregnant? No ❑ Yes ❑

Are you allergic to tape or adhesive? No ❑ Yes ❑

Regular use of Aspirin? No ❑ Yes ❑

Regular use of Ibuprofen, Advil, or Motrin? No ❑ Yes ❑

Have you had a cortisone injection in the last year? No ❑ Yes ❑

Have you ever had a blood transfusion? No ❑ Yes ❑

Are you opposed to having a blood transfusion? No ❑ Yes ❑

Have you ever been exposed to:

Intravenous Illegal Drugs No ❑ Yes ❑

Infectious Diseases No ❑ Yes ❑

Tuberculosis No ❑ Yes ❑

HIV No ❑ Yes ❑

Liver Transplant No ❑ Yes ❑

Hepatitis No ❑ Yes ❑

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Other health conditions, current or past (provide details)

Anesthetic Complications	No ❑	Yes ❑	_____
Anemia	No ❑	Yes ❑	_____
Asthma/Lung Disease	No ❑	Yes ❑	_____
Bruise or bleed easy/Bleeding Disorder	No ❑	Yes ❑	_____
Blood Clots (legs or lungs)	No ❑	Yes ❑	_____
Cancer (Including skin cancer)	No ❑	Yes ❑	_____
Diabetes	No ❑	Yes ❑	_____
Endocrine/Hormone Disorder	No ❑	Yes ❑	_____
Heart Disease/High/low blood pressure	No ❑	Yes ❑	_____
Infections/Immune system disorder	No ❑	Yes ❑	_____
Kidney Disease	No ❑	Yes ❑	_____
Liver disease/Hepatitis	No ❑	Yes ❑	_____
Neurological disease/Seizures	No ❑	Yes ❑	_____
Psychiatric/Mental disorder	No ❑	Yes ❑	_____
Pacemaker	No ❑	Yes ❑	_____
Stomach/Intestinal disorder	No ❑	Yes ❑	_____

Emotional History

Do you have any significant emotional problems?	No ❑	Yes ❑	_____
Have you ever had Psychiatric/Psychological care?	No ❑	Yes ❑	_____
Have you ever been diagnosed with Body Dysmorphic Disorder?	No ❑	Yes ❑	

Family Medical History: Do any relatives have any of the following (If yes who)

Asthma	No ❑	Yes ❑	_____
Blood or bleeding disorder	No ❑	Yes ❑	_____
Cancer	No ❑	Yes ❑	_____
Diabetes	No ❑	Yes ❑	_____
Epilepsy	No ❑	Yes ❑	_____
Heart Disease	No ❑	Yes ❑	_____
Lung Disease	No ❑	Yes ❑	_____
Kidney Disease	No ❑	Yes ❑	_____
Mental disorder	No ❑	Yes ❑	_____
Tuberculosis	No ❑	Yes ❑	_____

I certify that I am a mentally competent adult at least 18 years of age and that I have read this form and answered all questions truthfully to the best of my knowledge. I am responsible to notify the office and the physician if any changes occur in my medical condition. If I fail to keep the doctor informed of my full medical history, I may be at an increased risk for complications or unexpected results from the planned treatments. Witness

Witness _____ Patient _____

I certify that I am a mentally competent parent or legal guardian of the minor or mentally incompetent patient and that I have read this form and answered all questions truthfully and to the best of my knowledge.

Witness _____ Parent / Guardian _____

Cosmetic Questionnaire

Name: _____ Date: _____

Please check off any areas you would like to discuss with Dr. Azar at your appointment:

___ Botox
- __ Lines/Wrinkles
- __ Migraines
- __ Sweating

___ Filler
- __ Lips
- __ Cheeks
- __ Nasolabial Folds
- __ Under Eyes
- __Temples
- ___ Jawline

___ Skin quality/ correction
- ___Facial products
- ___Chemical peels
- ___Routine facials
- ___Micro Needling
- __Co2 Fractional laser

___Pigmentation
- ___Sun Damage
- ___Melasma
- ___Dark circles
- ___Age spots
- ___Birthmarks
- ___Blotchy skin
- ___Facial veins
- ___Spots on hands

___Medical concerns
- ___Skin cancer
- ___Lipoma
- ___Hemangioma
- ___New lesion
- ___Port-wine stain
- __ Broken capillaries
- __ Scars
- __ Excessive sweating

___Cosmetic concerns
- ___Droopy eyelids/eyebrows
- ___Longer/fuller eyelashes
- ___Hair removal
- ___Double chin
- ___Loose skin

__ Breasts
- __ Droopy
- __ Heavy
- __ Asymmetrical
- __ Small
- __ Lumps
- __ Tenderness
- __ Inverted nipples
- __ Large areolas
- __ Discharge
- __ Shoulder grooving
- __ Rashes
- __ Stretch marks
- __ Breast cancer
- __ Breast reduction
- __ Gynecomastia

__ Nose
- __ Too big
- __ Reduce hump on nose
- __ Difficulty breathing
- __ History of injury to nose
- __ Improve tip of nose
- __ Improve shape
- __ Previous surgery

__ Body
- __ Cellulite
- __ Excess fat
- __ Saggy skin
- __ Excess hair
- __ Brown spots
- __ Fat loss
- __ Arms
- __ Flanks/lower back
- __ Crepey skin

__Face
- __Jowls
- __Double Chin
- __Facial wrinkles
- __Mid face flattening
- __Loose skin/crepey skin neck
- __Large pores

__Ears
- __Prominent earlobes
- __Torn earlobes

Others, please specify: _____

_____

_____

HIPAA NOTICE OF PRIVACY PRACTICES

Dr. Azar and his office staff understand that health information about you is very personal and we are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to protecting your health information. We create a record of the care and services you recieve from us, and this record helps provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by us, and informs you about ways in which we may use and disclose information about you. We also describe your rights to the health information we keep on you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private and secure.
- Give you a notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For healthcare operations
- As required by law
- Health oversight activities
- Law enforcement
- Protective services for the president
- Security officials for inmates
- National security
- Required by militery or veterans and workers compensation
- Coroners, health examiners, and funeral directors
- For payment
- For appointment reminders
- Public health risks
- Lawsuits and disputes
- To avert a serious threat to health and safety

Your rights regarding health information about you:

- Right to inspect and copy
- Right to accounting of Disclosures
- Right to request confidential communication
- Right to ammend or correct
- Right to request restrictions or communication
- Right to choose someone to act for you

Your Medical Records: Your original copy and/or electronic medical record is the property of Azar Plastic Surgery. You may request a copy of your records to be transferred by completing a medical records release form. As allowed by California law, there will be a fee for providing you with this service. We require 30 business days from the date of your request to prepare and send your records unless the records are for urgent and/or life threatening health issues.

Changes to this Notice: We reserve the right to change this notice. We will post a copy of the current notice in our facility with the current effective date.

Complaints: If you believe that your privacy rights have been violated you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

For complete, detailed information regarding privacy laws, visit www.hhs.gov/ocr/privacy/hipaa/understand/consumers/noticepp.html

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Plastic Surgery & Med Spa

Permission to Share your Health Information: We are required by law to follow certain federal guidelines and laws regarding the confidentiality of your personal health information. One of these prevents us from discussing anything in your medical file with anyone other than yourself or other medical personnel involved in your care. If you would like us to discuss lab results or other personal information with your significant other, family members, or any other individuals, please fill in their name and relationship to you below.

_____ _____

_____ _____

Acknowledgement of Receipt of the Azar Plastic Surgery HIPAA Notice of Privacy Practices: We request that you sign this form acknowledging you have recieved, read, and reviewed the Azar Plastic Surgery HIPAA Notice of Privacy Practices. If the patient is a minor, the legal guardian is automatically appointed by law to provide/recieve protected information on behalf of the patient. I will notify Dr. Azar and/or his staff of any changes or updates to this record.

This acknowledgement will become part of your records.

Printed Name of Patient	Signature of Patient	Date
Printed Name of Legal Guardian	Signature of Legal Guardian	

Financial Policy

Welcome to Dr. Kouros Azar's office. We are committed to providing you with the highest quality of patient care. A clear understanding of our financial policy is important to our professional relationship. Should you have any questions regarding this financial policy, please ask our office manager for any clarification you may need.

- All patients must complete the patient information forms prior to seeing the doctor
- Full payment or co-payment / deductible is due at the time of service
- We accept cash, checks, and credit cards
- Any bank charges for returned checks will be added to the balance
- Financing is available through Care Credit and Alphaeon Credit

When surgical procedures are scheduled, surgical fees will be discussed privately between you and our staff. Surgical fees will be collected on the pre-operative appointment. Deposits collected for booking your surgery date are non-refundable and no office credit can be issued.

Dr. Azar is not contracted with any insurance companies, with the exception of Medicare. We file insurance claims as a courtesy to our patients. However, this does not release the patient/guarantor of their financial responsibility. Insurance coverage is a contract between you and your insurance company, we are not party to that contract.

Since the financial responsibility always resides with the patient, we want to keep you informed. For example, if 30 days have gone by and your insurance company has not paid, you may wish to call them directly to make sure your account is paid within 60 days. After 60 days, we will no longer pursue your insurance company, but will look to you, the patient, for payment.

PLEASE READ CAREFULLY: YOUR INSURANCE COMPANY MIGHT NOT FULLY REIMBURSE YOU FOR HOSPITAL ADMISSIONS OR SURGICAL PROCEDURES.

I, the undersigned, have read the above and realize that all medical and surgical charges incurred by me, or my dependents for services rendered are my financial responsibility. All court fees, attorney fees, or other necessary fees to collect this amount are payable by me.

Signature _____ Date _____

Witness _____ Date _____

Azar

Communication Consent

There are many ways to communicate with you. It is important to keep appointments and let us know if any problems or issues arise. All attempts will be made to preserve your privacy in accordance with HIPAA regulations.

Please confirm by checking below your preferred method of communicating with you:

___ Home #: _____ ___ Email: _____
___ Cell#: _____ ___ Text: _____

I consent to have a detailed voice message left on my preferred number: ___YES___ NO

I consent to receive SMS text messages regarding events and promotional information throughout the year: ___ YES ___ NO

I am aware that I can withdraw my consent at any time by informing Dr. Kouros Azar's Plastic Surgery and Med Spa either verbally or in writing.

Name: _____ Date: _____

Signature: _____

Witness: _____

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