



# PELED PLASTIC SURGERY

## COSMETIC HISTORY FORM

IF THIS IS YOUR FIRST VISIT WITH US, PLEASE TAKE THE TIME TO FILL THIS FORM OUT COMPLETELY.

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
E-mail address \_\_\_\_\_ Emergency Contact \_\_\_\_\_  
Emergency Contact Info \_\_\_\_\_  
Emergency Contact relationship to you \_\_\_\_\_  
Social Security#: \_\_\_\_\_ Preferred Contact \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_  
Reason for today's visit: \_\_\_\_\_

Are there specific health issues, procedures or products of interest to you? (Please check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Nose re-shaping (rhinoplasty)  | <input type="checkbox"/> Eyebrow lift                      |
| <input type="checkbox"/> Tummy tuck (abdominoplasty)  | <input type="checkbox"/> Breast augmentation               |
| <input type="checkbox"/> Liposuction  | <input type="checkbox"/> Eye rejuvenation (blepharoplasty) |
| <input type="checkbox"/> Facelift   | <input type="checkbox"/> Skin Care Advice                  |
| <input type="checkbox"/> Prominent ears (otoplasty)   | <input type="checkbox"/> Sunscreen Advice                  |
| <input type="checkbox"/> Arm lift (brachioplasty)   | <input type="checkbox"/> Skin Rejuvenation                 |
| <input type="checkbox"/> Male breast reduction  | <input type="checkbox"/> Birthmarks/Moles/Scarring         |
| <input type="checkbox"/> Latisse™ eyelash growth product                                      |  |
| <input type="checkbox"/> BOTOX Cosmetic™ or Dysport™ (i.e. Botulinum Toxin Type A)            |  |
| <input type="checkbox"/> Injectable fillers (e.g. Juvederm™, Radiesse™, Restylane™, Perlane™) |  |
| <input type="checkbox"/> Other, please specify _____  |  |

### PAYMENT OPTIONS:

- MasterCard & Visa are accepted
- Personal checks are accepted at least 14 days prior to surgery
- Payment financing is available via Care Credit

# PELED PLASTIC SURGERY

Do you currently have any of the following conditions?

	YES	NO		YES	NO		YES	NO
<b>EYES</b>			<b>ENDOCRINE</b>			<b>GENITOURINARY</b>		
Cataract(s)	<input type="checkbox"/>	<input type="checkbox"/>	Insulin dependent diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pain w/ urination	<input type="checkbox"/>	<input type="checkbox"/>
Visual disturbance(s)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes controlled with pills	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder infection	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes controlled with diet	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone(s)	<input type="checkbox"/>	<input type="checkbox"/>
Retinal problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
<b>EAR, NOSE, THROAT</b>			Parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus drainage	<input type="checkbox"/>	<input type="checkbox"/>	<b>CARDIAC</b>			<b>MUSCOLOSKELETAL</b>		
Nasal breathing issues	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Swelling	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESPIRATORY</b>			Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Herniated disk	<input type="checkbox"/>	<input type="checkbox"/>
Use oxygen at home	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Back pain/injury	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<b>NEUROLOGIC</b>		
<b>GASTROINTESTINAL</b>			Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chronic nausea	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac bypass	<input type="checkbox"/>	<input type="checkbox"/>	TIA (AKA "minor stroke")	<input type="checkbox"/>	<input type="checkbox"/>
Chronic vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac catheterization	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<b>SKIN</b>		
Black/bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	<b>HEME/LYMPH</b>			Moles	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Recent lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>	Poor scarring	<input type="checkbox"/>	<input type="checkbox"/>
Gall stones	<input type="checkbox"/>	<input type="checkbox"/>	Chronic lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>			
Hernia(s)	<input type="checkbox"/>	<input type="checkbox"/>						
Spleen problems	<input type="checkbox"/>	<input type="checkbox"/>						

## PAST MEDICAL HISTORY:

Have you ever had any of the following?

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer (other)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

If yes to any of the above, please describe the condition: \_\_\_\_\_

\_\_\_\_\_

## PAST SURGICAL HISTORY (including cosmetic surgery):

Please list any previous surgery with approximate dates:

Procedure	Date	Procedure	Date



# PELED PLASTIC SURGERY

**FAMILY HISTORY:**

Do you have **family members** with any of the following conditions:

Breast Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>MIGRAINES</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes to any of the above, please describe the condition and identify your relation to the family member: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS:**

Please list any prescription, non-prescription, and herbal medications you are taking along with doses. If you have a long list, please bring it to us.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DRUG ALLERGIES:** \_\_\_\_\_

**SOCIAL HISTORY:**

Marital Status: \_\_\_\_\_ Spouse's name \_\_\_\_\_

Are you currently employed? yes \_\_\_ no \_\_\_ If so, what do you do? \_\_\_\_\_

Do you smoke? yes \_\_\_ no \_\_\_ If so, how many packs per day? \_\_\_\_\_

If you smoked in the past, when did you quit? \_\_\_\_\_

On average, how many alcoholic drinks do you have per week? \_\_\_\_\_

**Insurance Information:**

Primary Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_



# PELED PLASTIC SURGERY

## OFFICE & INSURANCE BILLING AUTHORIZATION AND NOTIFICATION

By my signature below, I am authorizing PELED PLASTIC SURGERY to bill my insurance company for services provided. Occasionally, insurance companies send the insured party (yourself) reimbursement directly for medical services provided by their doctors. In such an event, any monies received directly by me for services rendered by Dr. Peled will be forwarded to this office within 2 weeks of receipt. In addition, any co-pays or deductibles will be paid in full within 2 weeks of any procedure or office visit as applicable. I further understand that Dr. Peled may or may not be a participating provider with my insurance plan. As such, the allowed amount according to my insurance company for any services/procedures rendered may be less than the amount charged by PELED PLASTIC SURGERY and I acknowledge that the difference will be my responsibility. I also acknowledge and understand that there will be a fee of \$25.00 (per form up to 4 pages and an additional \$25.00 fee for each additional 4 pages of paperwork over the initial 4 pages) to complete any paperwork associated with my care. Finally, any appointments not cancelled **AT LEAST 24 HOURS** prior to the scheduled time will be subject to a \$50 cancellation fee. I further acknowledge that any questions regarding these matters have been answered by Dr. Peled and/or his staff.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

\_\_\_\_\_  
Relationship



# PELED PLASTIC SURGERY

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have been presented with a copy of Peled Plastic Surgery's 'Notice of Privacy Practices' (ask Cary-Anne for a paper copy; they are also available online at all times at this address - <http://www.peledmigrainesurgery.com/forms.html>), detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of these 'Practices', and I request the following restriction(s) concerning the use of my personal medical information:

---

---

---

---

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

### NOTICE TO CONSUMERS

**Medical doctors are licensed and regulated by the Medical Board of California  
(800) 633-2322  
[www.mbc.ca.gov](http://www.mbc.ca.gov)**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

\_\_\_\_\_  
Relationship