

DR. ROBERT APPLEBAUM

BOARD CERTIFIED - AMERICAN BOARD OF PLASTIC SURGERY
BEVERLY HILLS, CALIFORNIA

Patient Information

NAME: _____ AGE: _____ BIRTH DATE: ____/____/____
HOME ADDRESS: _____ CITY: _____
STATE: _____ ZIP: _____ OCCUPATION: _____
GENDER: M / F MARITAL STATUS: M S D W CELL PHONE: _____
HOME PHONE: _____ OTHER PHONE: _____
WHAT IS THE BEST PHONE NUMBER FOR US TO CONTACT YOU? _____
SOCIAL SECURITY #: _____ DRIVER'S LIC. #: _____

EMAIL ADDRESS: _____ May we add you to our mailing list? Y N
HOW WERE YOU REFERRED TO OUR OFFICE? _____

EMPLOYER NAME AND ADDRESS: _____
WORK TELEPHONE NUMBER: _____
May we contact you at your work number? Y N

EMERGENCY CONTACT (NOT LIVING WITH PATIENT): _____
ADDRESS: _____ CITY: _____
STATE: _____ ZIP: _____ PHONE: _____
ALTERNATE PHONE: _____

PRIMARY INSURANCE: NAME: _____ PHONE: _____
NAME OF INSURED: _____ SEX: _____ D.O.B. _____
GROUP OR POLICY #: _____ CERT. OR I.D.# _____

WHAT IS THE PURPOSE OF THIS CONSULTATION? _____

PRIMARY PHYSICIAN: _____
ADDRESS: _____ CITY: _____
STATE: _____ PHONE: _____

Insurance Assignment

I irreversibly assign to Dr. Robert Applebaum all my right, without limitation, pertaining to my insurance carrier relating to services that Dr. Applebaum provided to me. I understand and agree that Dr. Applebaum may pursue those rights through demand letters, settlement, and litigation until finished, and that Dr. Applebaum will keep all money paid by my insurance carrier.

I understand and agree that Dr. Applebaum may irreversibly reassign such matters and payments to someone else in order to pursue these matters. I direct my insurance carrier to pay all sums directly to Dr. Applebaum or to the party receiving the reassignment.

I, _____, HAVE CAREFULLY READ AND UNDERSTAND THIS ASSIGNMENT, AND ACCEPT, APPROVE, AND AGREE TO THIS ASSIGNMENT.

(Authorized Signature)

(Date)

NOTE: THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL AND SURGICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON WITHOUT YOUR AUTHORIZATION.

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PERSONAL HISTORY-ILLNESS

HAVE YOU EVER HAD?

- YES NO HIGH BLOOD PRESSURE
- YES NO LOW BLOOD PRESSURE
- YES NO HEART DISEASE
- YES NO HEART ATTACKS
- YES NO BLOOD CLOTS
- YES NO MRSA SKIN INFECTION
- YES NO STROKE
- YES NO DIABETES
- YES NO SINUS TROUBLE
- YES NO ASTHMA
- YES NO EMPHYSEMA
- YES NO STOMACH ULCER
- YES NO BLADDER INFECTION
- YES NO CIRRHOSIS
- YES NO HEPATITIS
- YES NO TUBERCULOSIS
- YES NO CANCER
- YES NO THYROID DISEASE
- YES NO EPILEPSY / SEIZURES
- YES NO VENEREAL DISEASE
- YES NO HIV POSITIVE TESTING
- YES NO ANEMIA
- YES NO SKIN INFECTIONS

ANY OTHER DISEASE? _____

ALLERGIES

ARE YOU ALLERGIC TO:

- YES NO PENICILLIN
- YES NO SULFA
- YES NO ASPIRIN
- YES NO CODEINE
- YES NO LATEX

LIST ANY ALLERGIES TO MEDICATIONS, FOOD
OR CHEMICALS:

MEDICATION HISTORY

PLEASE LIST ALL MEDICATIONS TAKEN
EITHER REGULARLY OR OCCASIONALLY:

PLEASE CIRCLE IF YOU ARE TAKING ANY OF THE FOLLOWING
ON A REGULAR BASIS:

ASPIRIN MOTRIN ADVIL DIET PILLS Describe Usage: _____

PLEASE DESCRIBE CURRENT DIETARY SUPPLEMENTS, HERBS, OR HOMEOPATHIC REMEDIES YOU ARE TAKING:

HEIGHT _____ WEIGHT _____

REVIEW OF SYSTEMS

DO YOU HAVE OR HAVE YOU
EVER HAD LONG-STANDING?

- YES NO COUGH
- YES NO SHORTNESS OF BREATH
- YES NO CHEST PAIN OR ANGINA
- YES NO PALPITATIONS
- YES NO NAUSEA OR VOMITING
- YES NO DIARRHEA
- YES NO CHRONIC HEADACHES
- YES NO DIZZINESS
- YES NO DO YOU BRUISE EASILY?
- YES NO DO YOU BLEED EASILY?

SURGICAL HISTORY

PLEASE LIST ALL PRIOR SURGERYS:

ANESTHESIA HISTORY

HAVE YOU EVER HAD PROBLEMS
WITH ANY PREVIOUS LOCAL OR
GENERAL ANESTHETIC AGENTS?
IF YES, PLEASE GIVE DETAILS:

ALCOHOL AND TOBACCO HISTORY

YES NO DO YOU SMOKE?

IF YES, WHEN _____

YEARS SMOKED _____

PACKS PER DAY _____

DO YOU DRINK ALCOHOLIC BEVERGES?

_____ NEVER _____ RARELY

_____ SOCIALLY _____ MODERATE

YES NO DO YOU WEAR CONTACT LENSES?

YES NO DO YOU WEAR ANY REMOVABLE
DENTAL APPLIANCES?

YES NO ADVANCE DIRECTIVE?

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PERSONAL HEALTH INFORMATION FORM

ROBERT APPLEBAUM, M.D.
SYLVIE LEMAY, R.N.
FOUR THIRTY SIX AESTHETIC SURGERY CENTER

As per HIPPA rules and regulations you are required to inform this office how you would like us to communicate with you in regards to your Personal Health Information (PHI). Our office may need to contact you to confirm your appointment, schedule surgery, return your phone calls or to give you results of labs, x-rays, scans, or other medical testing. Per HIPPA we are required to follow your written instructions, except where we feel following the instructions would be detrimental to your health or in case of emergency.

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

Please be specific as to how we are to reach you, where we can leave messages and with whom.
Please fill in or circle:

You may / may not call me at my home phone number: _____

You may / may not leave a message on my home answering machine. You may leave a message with (please circle) no one, my spouse, my children, other: _____

You may / may not call me on my cell phone number.

You may / may not leave a message on my cell phone voice mail.

You may change your decision at any time by filing a request form change and fax it to us at (310) 550-8822.

Patients Signature (or Personal Representative)

Date: _____

Printed name of representative / relationship with Patient

Date: _____

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Advanced Directive Policy Agreement

Compliance with the 1990 Patient Self-Determination Act is intended solely for inpatient hospital admissions and not for outpatient surgery centers. 436 Aesthetic Surgery Center does not honor an Advance Directive. All healthcare providers at 436 Aesthetic Surgery Center are bound to do all in their power to ensure the safe recovery of every patient, including resuscitation if and when appropriate.

Upon patient admission to 436 Aesthetic Surgery Center a patient may supply a copy of their Advanced Directive to the surgery center. In the event of an unforeseen medical emergency requiring a patient admission and or transferred to an inpatient hospital, the advanced directive shall be included in the patient medical record file from our 436 Aesthetic Surgery Center. The inpatient hospital may honor the advanced directive if and when appropriate

_____ I have read the advanced directive policy

_____ I have been informed and understand that 436 Aesthetic Surgery Center does not honor in advance directive during my outpatient admission and surgery procedure.

Please choose one of the following:

_____ I have an advance directive and have supplied 436 Aesthetic Surgery Center with a copy in the unforeseen event of an inpatient hospital admission or transfer.

_____ I do not have an advanced directive.

Patient signature: _____

Date: _____

Witness signature: _____

Date: _____