DR. ROBERT APPLEBAUM

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

Patient Information

CHILD'S NAME: _____ GENDER: _____ AGE_____
BIRTHDATE: ____/____/____ STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ SOC. SEC.#: _____
PRIMARY PHONE: _____ SECONDARY PHONE: _____
CIRCLE ONE (CELL / HOME / WORK) (CIRCLE ONE (CELL / HOME / WORK)
EMAIL ADDRESS: _____ May we add you to our mailing list? Y N
HOW WERE YOU REFERRED TO OUR OFFICE? _____

FAMILY PHYSICIAN: _____
ADDRESS: _____ **CITY:** _____
STATE: _____**PHONE #:** _____

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

MOTHER'S NAME: _____ SOC.SEC.# _____
MOTHER'S EMPLOYER: _____ WORK PH.# _____

FATHER'S NAME: _____ SOC.SEC# _____
FATHER'S EMPLOYER: _____ WORK PHONE: _____

NAME AND ADDRESS OF CLOSE FRIEND OR RELATIVE (NOT LIVING WITH CHILD):
_____

CITY: _____ STATE: _____PH.# _____

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.

_____ _____
(Parent/Guardian 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.

DR. ROBERT APPLEBAUM

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

NOTE: THIS IS A CONFIDENTIAL RECORD OF THE PATIENT'S MEDICAL AND SURGICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION LISTED HERE WILL NOT BE RELEASED TO ANY PERSON WITHOUT PATIENT AUTHORIZATION.

PERSONAL HISTORY-ILLNESS
HAS THE PATIENT 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 EPILESPHY / SEIZURES
YES NO VENEREAL DISEASE
YES NO HIV POSITIVE TESTING
YES NO ANEMIA
YES NO SKIN INFECTIONS

ANY OTHER DISEASE?_____

_____

_____

ALLERGIES
IS THE PATIENT 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:
_____

_____

REVIEW OF SYSTEMS
DOES THE PATIENT HAVE OR HAVE 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

HAS THE PATIENT EVER HAD PROBLEMS WITH ANY PREVIOUS LOCAL OR GENERAL ANESTHETIC AGENTS?
IF YES, PLEASE GIVE DETAILS:
_____

_____

ALCOHOL AND TOBACCO HISTORY
YES NO DOES THE PATIENT SMOKE?

IF YES, WHEN_____
YEARS SMOKED_____
PACKS PER DAY_____
DOES THE PATIENT DRINK ALCOHOLIC BEVERGES?
_____NEVER _____ RARELY
_____SOCIALLY _____MODERATE

YES NO DOES THE PATIENT WEAR CONTACT LENSES?
YES NO DOES THE PATIENTS WEAR ANY REMOVABLE DENTAL APPLIANCES?

PLEASE CIRCLE IF THE PATIENT IS 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 THE PATIENT IS TAKING:
_____

HEIGHT_____WEIGHT_____

DR. ROBERT APPLEBAUM
BOARD CERTIFIED - AMERICAN BOARD OF PLASTIC SURGERY
BEVERLY HILLS, CALIFORNIA

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 Parent/Guardian Signature:

_____ Date: _____

Printed name of parent/guardian and relationship to Patient:

_____ Date: _____

DR. ROBERT APPLEBAUM
BOARD CERTIFIED - AMERICAN BOARD OF PLASTIC SURGERY
BEVERLY HILLS, CALIFORNIA

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

____ The patient has read the advanced directive policy

____ The patient has been informed and understand that 436 Aesthetic Surgery Center does not honor an advance directive during the outpatient admission and surgery procedure.

Please choose one of the following:

____ The patient has an advance directive and has supplied 436 Aesthetic Surgery Center with a copy in the unforeseen event of an inpatient hospital admission or transfer.

____ The patient does not have an advanced directive.

Patient's parent/guardian signature: _____ Date: _____

Witness signature: _____ Date: _____