Dr. Som
AESTHETIC, PLASTIC & RECONSTRUCTIVE SURGERY

PATIENT'S INFORMATION

Last Name First Name Middle Name	Sex ☐ M ☐ F	Age	Birthdate ____/____/_____
Patient's Address			
City State Zip code			

Home Phone ( )	Mobile Phone ( )	Social Security Number
Marital Status (Please Circle One) Single Married Divorced Separated Widowed		Email Address
Occupation		Language Spoken
Employer's Name		Office Phone ( )
Primary Care Physician		Office Phone ( )
Referring Physician		Office Phone ( )

PERSONAL INSURANCE INFORMATION - PRIMARY

Subscriber's Name	Patient's Relationship to Subscriber
Insurance	ID Number

PERSONAL INSURANCE INFORMATION - SECONDARY

Subscriber's Name	Patient's Relationship to Subscriber
Insurance	ID Number

NAME OF RELATIVE OR FRIEND – NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)

Name/Relationship	Phone ( )

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize SOM K PLASTIC SURGERY to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits.

Patient's Signature	Date

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COMPREHENSIVE PATIENT HISTORY

Patient's Name:	Date:

What is the main reason for your visit today? (Please Describe)

_____

_____

_____

MEDICATION YOU ARE TAKING (Prescriptions and non-prescriptions, including aspirin, ibuprofen, Advil, Aleve, Ecotrin, Vitamins. Please include dosage and frequency.)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ALLERGIES TO FOOD/MEDICATION (INCLUDING TYPE OF REACTION)

1. _____ 3. _____
2. _____ 4. _____

MEDICAL HISTORY (Please indicate if you have or have had any of the following by encircling Yes or No, followed by a brief explanation, including dates.)

Cardiac Disease (Type)	YES	NO	_____
Lung Disease (Type)	YES	NO	_____
Liver Disease/Hepatitis	YES	NO	_____
Kidney Disease	YES	NO	_____
Diabetes	YES	NO	_____
Cancer	YES	NO	_____
Seizure Disorders	YES	NO	_____
High Blood Pressure	YES	NO	_____
Bleeding Disorder/Tendency	YES	NO	_____
Orthopedic Prosthesis/Implant	YES	NO	_____
Thyroid Disease	YES	NO	_____
Gastrointestinal Disorder	YES	NO	_____
Other Conditions (Specify)	YES	NO	_____

(Women) Number of Pregnancies: _____ Vaginal Deliveries: _____ C-sections: _____

SURGICAL HISTORY (Please list all operations that you have had and when they were done.)

_____

_____

_____

FAMILY HISTORY (Please list any family history of cancer, skin disorders, second or third degree relatives)

_____

_____

_____

SOCIAL HISTORY (Tobacco use, Alcohol use, Recreational drug use, Occupation current or previous)

Tobacco use: ___ packs per day, How many years: ____, Previous use: _____

Occupation: _____

_____

SOM K PLASTIC SURGERY, 8631 W. 3rd St. Suite 200E, Los Angeles, CA 90048
Phone: 424-239-9743 Fax: 310-289-1526

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INFORMED CONSENT - PHOTOGRAPHIC RELEASE

I hereby voluntarily grant permission to Som Kohanzadeh, SOM K Plastic Surgery, and their designated representatives or employees to take any preoperative, intraoperative and postoperative photographs of myself for purpose of record, education, to assist the Doctor in the performance of my surgery. I authorize submission of my photographs to insurance carriers for their use in predetermining coverage of my surgery. I understand that no form of compensation shall become payable to me for these photographs. I understand and accept that I may be recognized from my likeness or case history. Nevertheless, I authorize the Doctor to use my photographs, videotapes, and case information in the following education and scientific setting. I hereby voluntarily grant permissions:

- Lectures and multi-media presentations for an audience of medical professionals or at which members of the press may be present
- Publication in medical, surgical and scientific journal articles and textbooks, online and on the physician's website for patient examples.
- Research projects to evaluate efficacy of my surgery and its outcomes
- I grant permission for the use of any record, illustration, photograph or other imaging record created in my case, for credentialing and/or certifying purposes by **The American Board of Plastic Surgery, Inc** and potential use in the examination/testing by the **American Board of Plastic Surgery.**
- I authorize use by professional associations, including but not limited to, the not-for-profit **American Society for Plastic Surgery** and the **American Society of Aesthetic Plastic Surgeons**, to use my photographs and case information in fulfilling its mission of public education, including education brochures, video tapes, slide presentations available for purchase and case studies presented on the Societies' web sites.

I will allow the Doctor and his office to submit my case information and photographs to the appropriate agencies to facilitate precertification or appeal processes.

_____ _____
Patient's Name Date

_____
Patient's Signature

_____ _____
Witness' Name Date

_____
Witness' Signature