

Hedieh Arbabzadeh, M.D. F.A.C.S.
BOARD CERTIFIED PLASTIC SURGEON



****Please print legibly and fill in all fields****

Patient Name: _____
Last First Middle Initial

Address: _____
Street/Apt # City State Zip

Home Phone: _____ Cell Phone: _____ Other: _____
Any restrictions calling you? Yes / No Restrictions: _____

E-mail: _____ Driver License# / State: _____

Age: _____ Date of Birth: ____ / ____ / ____ Sex: Male / Female / Transgender

Social Security #: _____ - _____ - _____ Marital Status: Single / Married / Domestic Partnership

Mother's Maiden Name: _____ (Augmentation patient only)
Patient Birth City/ State: _____ (Augmentation patient only)

Employer: _____ Occupation: _____

Work Address: _____ Is it ok to contact at work? Yes / No

Emergency Contact

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Other: _____
Address: _____
Street/Apt # City State Zip

If Applicable:

Primary Insurance Company: _____
Policy #: _____ Group# _____
Insurance Phone: _____ Referral Required? Yes/ No
Co-pay: Yes / No \$ _____ HMO / PPO
Policy Holder Name: _____ Policy Holder DOB: ____ / ____ / ____

Secondary Insurance Company: _____
Policy #: _____ Group# _____
Insurance Phone: _____ Referral Required? Yes/ No
Co-pay: Yes / No \$ _____ HMO / PPO
Policy Holder Name: _____ Policy Holder DOB: ____ / ____ / ____

Primary Care Physician / Referring Physician: _____
How did you hear about our office: _____

I understand that office visit charges are payable on the day of service is rendered. I authorize Dr. Arbabzadeh to bill my Insurance Company regardless of insurance coverage; I am responsible for all bills being paid in a timely manner. I understand that my contact is between Dr. Arbabzadeh and Myself. Initial: _____

Signature _____

Date _____

HEDIEH ARBABZADEH, M.D., F.A.C.S

Board Certified Plastic Surgeon

Consent for Photography

Patient Name: _____

I do hereby give permission for the photographs to be taken for the purpose of:

Photo documentations will be filed in my medical record chart. These photos will include but not limited to before and after surgery photos.

If Dr. Arbabzadeh takes a picture of your face, *it will be used for identification purposes only*, in your chart.

I Agree

I Do Not Agree

I give permission to release my photographs to be used for the purpose of education. This may include but not limited to the presentation to patients or potential patients, including print and website publications.

I agree

I Do Not Agree

Patient Signature: _____

Date: _____

Witness: _____

Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices

Heideh Arbabzadeh

Medical Corporation

2365 E. Fir Ave

Fresno, Ca 93720

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Patient Signature: _____

Date: _____

Print Name: _____

If not signed by the patient, please indicate the relationship:

Parent/Guardian of minor patient.

Guardian/Conservator of an incompetent patient.

Name of Patient: _____