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:_____

Patient Name:_____

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

Medical History

Please complete this form to the best of your knowledge. The information is necessary to make important decisions regarding your medical care. Please answer thoroughly.

PATIENT NAME: _____
Last **First** **Middle**

Occupation: _____ **Height:** _____ **Weight:** _____ **Age:** _____

Chief Complaint *(Reason for visit)* : _____

Do you have any of the following medical conditions? CIRCLE ALL THAT APPLY.

NERVOUS SYSTEM	Epilepsy Seizures Stroke Mental Illness
HEART	Heart Attacks Hypertension Irregular Heart Beats
LUNGS/ AIRWAY	Asthma Emphysema Shortness of Breath
SMOKE	Packs per day: # Years:
LIVER	Cirrhosis Hepatitis Other Liver Disease
GI / GU	Hiatal Hernia w/ Reflux Ulcers Kidney Disease
ENDOCRINE	Diabetes Thyroid Disorders Unexplained Weight Loss/Gain
EAR / EYE	Contact Lenses Glasses Hearing Aids Hard of Hearing
BREAST	Nipple Numbness Breast Pain Rashes Under or Between Breast Breast Lump
Mammogram	Date/Result: Current Bra Size:
MUSCULOSKELETAL	Metal Implants Arthritis Piercing/Cut Skin
ANESTHESIA	Adverse reactions: *(Explain)*

Previous Surgeries: *(include dates)* _____

Previous Accidents/Injuries: _____

Medications/Dietary Supplements: *(including dosage)* _____

_____

Allergies: _____

Family History: Diabetes / Coronary Artery Disease / Heart Attack / Stroke / Bleeding Problems / Breast Cancer / Melanoma / Explain: _____

Patient Signature: _____ ***Date:*** _____

Medical Staff Only:

VITALS

BP_____/_____

PULSE: _____

TEMP: _____

BMI: _____

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: _____

Hedieh Arbabzadeh M.D. F.A.C.S.
Medical Corporation
7050 N Recreation Ave Suite 102
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 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: _____