

**MOSSI SALIBIAN, M.D.**  
PLASTIC & RECONSTRUCTIVE SURGERY

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Marital Status \_\_\_\_\_

Drivers License # \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

REASON FOR TODAY'S VISIT \_\_\_\_\_

WHO REFERRED YOU TO OUR OFFICE \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

**SPOUSE OR PARENTS INFORMATION:**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employers Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If patient is minor, who is legally responsible? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Insurance Co. \_\_\_\_\_

Member # \_\_\_\_\_ Group # \_\_\_\_\_

Policyholder's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insurance Phone: \_\_\_\_\_

Are you under the care of a physician at this time? If so, please provide the doctor's phone number and the reason for the treatment.

Doctor's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Condition being treated for \_\_\_\_\_

Check any of the following that you have had or your family has had in the past::

	<u>Personal History</u>	<u>Family History</u>	<u>Laser patients</u>	
High Blood Pressure	_____	_____		
Any Blood Disorders	_____	_____	Do you have a history of herpes?	yes/no
Blood clots (DVT)	_____	_____		
Blood Transfusion	_____	_____	Do you have tattoo's?	yes/no
Thyroid Problems	_____	_____		
Breathing Difficulty	_____	_____	Have you tanned in the last month?	yes/no
Asthma	_____	_____		
Chest Pain	_____	_____	Have you used self tanning products in the last month?	yes/no
Heart Disease	_____	_____		
Palpitations/Murmur	_____	_____	Have you used Retin A in the last 3 months?	yes/no
Any Stomach Disorders	_____	_____		
Hepatitis or Jaundice	_____	_____	Have you used Accutane in the last 3 months?	yes/no
Diabetes	_____	_____		
Cancer	_____	_____		
HIV or AIDS	_____	_____		
Autoimmune disease	_____	_____		
Arthritis	_____	_____		
Neurologic Disorders	_____	_____		
Stroke	_____	_____		
Seizures	_____	_____		
Urinary Tract Infections	_____	_____		
Steroid Dependence	_____	_____		
Alcohol Dependence	_____	_____		

Have you ever had any significant medical illness not noted on this form? \_\_\_\_\_

\_\_\_\_\_

Please list all previous surgeries including cosmetic

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Are you **Allergic** to any medications? If so, please list.

\_\_\_\_\_

What medications are you currently taking? (Include aspirin, birth control pills, vitamins and diet pills)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you smoke cigarettes or have you smoked in the past five years: \_\_\_\_\_ Yes \_\_\_\_\_ No

Approximately how much alcohol do you drink (Number of drinks per week) \_\_\_\_\_

Do you habitually use recreational drugs: \_\_\_\_\_ Yes \_\_\_\_\_ No

**WOMEN ONLY**

Are you currently pregnant? Yes/no

Number of Pregnancies \_\_\_\_\_ Number of Live Births \_\_\_\_\_

Have you ever had a mammogram? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please state the date of your last mammogram \_\_\_\_\_

**CONSENT FOR MEDICAL PHOTOGRAPHY**

Photographs are an important part of the medical record. They are used to document a patient's appearance before, during and after treatment. I hereby grant permission to Dr. Mossi Salibian, and his staff to obtain appropriate medical photographs of me. These images may be used for professional medical educational purposes, including lectures, photo album and website presentations.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**ASSIGNMENT OF BENEFITS: FINANCIAL AGREEMENT**

I hereby assign all medical or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private Insurance, and any other Health Plan to: Mossi Salibian, M.D. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I understand that I am responsible for any amount due after your payment of this claim:

PATIENT (PRINT NAME): \_\_\_\_\_

SIGNATURE OF PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_