Mossi Salibian, M.D., F.A.C.S
Plastic and Reconstructive Surgery
9201 W. Sunset Blvd. Suite 917
West Hollywood, CA, 90069

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:

	Personal History	Family History
High Blood Pressure		
Blood clots (DVT)		
Any Blood Disorders		
Blood Transfusion		
Thyroid Problems		
Breathing Difficulty		
Asthma		
Chest Pain		
Heart Disease		
Palpitations/Murmur		
Any Stomach Disorders		
Hepatitis or Jaundice		
Diabetes		
Cancer		
HIV or AIDS		
Arthritis		
Autoimmune disease		
Neurologic Disorders		
Stroke		
Seizures		
Urinary Tract Infections		
Steroid Dependence		
Alcohol Dependence		

Laser patients

Do you have a history of herpes ?	Yes	No
Do you have tattoo's?	Yes	No
Have you tanned in the last month?	Yes	No
Have you used self-tanning in the last month?	Yes	No
Have you used Retin A in the last 3 months?	Yes	No
Have you used Accutane in the last 3 months?	Yes	No

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 and the reaction they cause.

____

☐ Check if No Known Drug Allergies

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.

☐ Check, if you would like your pictures used for your chart ONLY and not be made public.

Patient Signature ___________________________________ Date___________________________

ASSIGNMENT OF BENEFITS: FINANCIAL AGREEMENT

Medical insurance coverage is a contract between you and your insurance company. WE ARE NOT a party to this contract. We will not be involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. You are ultimately responsible for the timely payment of your account.

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

PATIENT (PRINT NAME): ____

SIGNATURE OF PATIENT: ____

DATE: ____

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Cosmetic Questionnaire

Name: ____ Date: ____________________

Email: ____

Please check any/all of the following that you currently have an interest in and would like to learn more about:

__ Botox cosmetic treatments
__ Facial skin rejuvenation / Laser Facial / CO_2 Laser Treatments
__ Chemical peels (such as Jessner's and TCA)
__ Facial cosmetic fillers i.e.: Juvederm, Restylane, Radiesse, Perlane, and Sculptra
__ Facial cosmetic surgery i.e.; face and neck lift, eyelid and eyebrow / forehead lift, nose surgery, facial implants: chin or cheek, ear pinning, buccal fat-pad removal
__ Cosmetic surgery i.e.: breast augmentation, rhinoplasty, tummy tuck, breast lift
__ Liposuction and body contouring procedures
__ Body contouring post weight loss: circumferential body lift, thigh lift, arm lift
__ Breast reduction
__ Breast Reconstruction (for breast cancer or breast deformities)
__ Male chest reduction (procedures for gynecomastia)
__ Chest Reconstruction / Poland's Syndrome
__ Removal of cysts, moles, and skin cancers and other lesions
__ Repair of torn or stretched ear lobes
__ Botox to eliminate underarm sweating
__ Laser treatment for hair removal
__ Laser treatment for sunspots and age-spots
__ Laser and sclerotherapy for varicose or spider veins for face and body
__ Latisse - eyelash growth product

I would like information about the following problems:

1) ____________________
2) ____________________
3) ____________________
4) ____________________

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I ________________________ have reviewed and been offered a copy of Dr. Mossi Salibian's Notice of Privacy Practices.

________________________ ________
Signature of Patient Date

________________________ ________
Signature of Witness Date