AESTHETICARE
30260 Rancho Viejo Road
San Juan Capistrano, California 92675
(949) 661-1700

Todays date_____ Consultant_____

PATIENT INFORMATION email address:_____
birthdate:___/___/_____age:_____ OK to email? Y or N
NAME:first_____middle_____last_____
ADDRESS:_____CITY:_____
STATE:_____ZIP CODE:_____
PHONE: HOME ( )_____WORK ( )_____STATUS: S M D W
OK TO CALL AT HOME? Y or N OK TO LEAVE MESSAGE AT HOME? Y or N
OK TO CALL AT WORK? Y or N OK TO LEASE MESSAGE AT WORKQ Y or N
EMPLOYER NAME:_____SSN#:_____
EMPLOYER ADDRESS:_____CITY:_____
STATE:_____ZIP CODE:_____

RESPONSIBLE PARTY: PARENT/SPOUSE INFORMATION

NAME:first_____middle_____last_____
RELATIONSHIP:_____BIRTHDATE:_____
ADDRESS:_____CITY:_____
STATE:_____ZIP CODE:_____
PHONE: HOME: ( )_____WORK: ( )_____
EMPLOYER NAME:_____SSN#_____
EMPLOYER ADDRESS:_____CITY:_____
STATE:_____ZIP CODE:_____

INSURANCE INFORMATION

INSURED NAMED:_____GROUP:_____
PRIMARY INSURANCE :_____I.D.#_____
ADDRESS:_____
TELEPHONE: ( )_____VERIFICATION:_____
SECONDARY INSURANCE :_____I.D.#_____
ADDRESS:_____
TELEPHONE: ( )_____VERIFICATION:_____

EMERGENCY NOTIFICATION

NAME:_____RELATIONSHIP:_____
ADDRESS:_____PHONE: ( )_____
CITY:_____STATE:_____ZIP CODE:_____

PAYMENT INFORMATION

FORM OR PAYMENT: CASH/CHECK/CC:____INSURANCE:____FINANCE:____
WHO REFERRED YOU: Internet Yellow Pages Mail Ad Friend
REFERRED BY:_____DRIVER'S LICENSE#:_____

INSURANCE BENEFITS CONTRACT

IF YOU HAVE HEALTH INSURANCE, THIS IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. IF THE EXPENSE BENEFITS ALLOWABLE DOES NOT COVER THE BALANCE OF YOUR OBLIGATION, THEN YOU WILL BE RESPONSIBLE FOR THE BALANCE OWED. YOU AGREE BY SIGNING BELOW.

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California. (800)633-2322 www.mbc.ca.gov

_____ _____ _____
signature date witness

I. HISTORY OF ILLNESS AND MEDICAL PROBLEMS

Do you now have OR have you ever had any of the following? Circle YES or NO. Please explain any YES answers, including dates.

EXPLAIN

Do you wear contact lenses or glasses.....Yes No
Eye or eyelid infection.....Yes No
Glaucoma or other eye problems.....Yes No
Ear trouble or hearing aid.....Yes No
Deafness or decreased hearing.....Yes No
Thyroid trouble.....Yes No
Strep Throat.....Yes No
Cold, cough or sore throat in last 2 weeks.....Yes No
Loose teeth, false teeth or caps.....Yes No
Unusual headaches, dizziness or blackout spells..Yes No
Head injury or nervous system problems.....Yes No
Stroke, paralysis, muscle weakness or numbness...Yes No
Convulsions or Seizures.....Yes No
Pneumonia, emphysema, bronchitis or wheezing.....Yes No
Allergies to pollens, asthma or hayfever.....Yes No
Tuberculoses or Valley Fever.....Yes No
Shortness of breath or other lung problems.....Yes No
High blood pressure.....Yes No
Heart attack.....Yes No
High cholesterol.....Yes No
Heart murmur, skip beats or beat irregularly.....Yes No
Chest pain, angina or other heart condition.....Yes No
Arteriosclerosis (hardening of arteries).....Yes No
Stomach/duodenal ulcer.....Yes No
Diverticulosis or other bowel problems.....Yes No
Hepatitis, yellow jaundice or cirrhosis.....Yes No
Gallbladder trouble.....Yes No
Hernia-Incisional, abdominal, inguinal or hiatal.Yes No
Hemorrhoids.....Yes No
Kidney disease or stones, blood in your urine....Yes No
Bladder or urinary disease.....Yes No
Prostate problem.....Yes No
Menstrual problems or irregularities.....Yes No
Arthritis or Gout.....Yes No
Cancer or tumor.....Yes No
Bleeding tendency, anemia or blood diseases.....Yes No
Thrombophlebitis (blood clots) you or family.....Yes No
Diabetes or other glandular problems.....Yes No
Measles/Rubeola.Yes No Mononucleosis.....Yes No
Eczema.....Yes No Venereal Disease.....Yes No
Polio.....Yes No Rheumatic Fever.....Yes No
Mumps.....Yes No Chicken Pox.....Yes NO
Rheumatic fever.Yes No German Measles/Rubella.Yes No
Congenital abnormalities.....Yes No
Motion sickness.....Yes No
Have you ever had a blood transfusion.....Yes No
Do you have any prosthesis or implants.....Yes No
Any physical limitations in your neck or back....Yes No
Sleep Apnea.....Yes No

If female, date of your last menstrual period:_____

Your present height:_____ Your present weight:_____

NAME:_____ DATE:_____

IMPORTANT !! Are you now or have you ever been under the care of a Psychiatrist or Psychologist for any mental illness including depression, anxiety, mood swings, hallucinations or any other psychiatric symptoms or illnesses?.....YES NO
If yes, please elaborate_____

_____

_____

II. HOSPITALIZATION, SURGERIES, INJURIES OR CHRONIC ILLNESSES:

Have you ever been hospitalized, operated on or seriously injured. YES NO If YES please complete the following.

Year	Operations, Illness, Injury	Hospital & City
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you or any relative had problems with anesthesia? YES NO
If YES, Please explain:_____

III. ARE YOU CURRENTLY UNDER A DOCTOR'S CARE FOR ANY REASON?
If YES, Please explain:_____

IV. MEDICATIONS:
Do you take any medications YES NO If YES list and explain.

_____

_____

Are You Taking FEN/PHEN YES NO If YES, Last date taken _____
Are You Taking ANY diet pills YES NO. Last date taken _____
Do you take any vitamins, minerals or supplements YES NO.
Please list all medicines that you take and the daily dose:

_____ _____ _____

_____ _____ _____

Please check any of the following drugs that you take.
Anti-depression, anti-psychotic or mood altering drugs ( )
Inderal ( ) Aspirin ( ) Vitamin E ( ) Steroids ( )

V. SOCIAL HISTORY:

Please Circle one each of the following choices:

Alcohol: Never Rarely Moderate Daily

Cigarettes or tobacco: YES NO If YES, how many packs/day:___

Have you ever had a dependency on drugs and/or alcohol? YES NO

Do you currently use any recreational or "street" drugs including marijuana, cocaine, heroin: YES NO If yes, which:_____

Do you exercise? Type:_____ How often:_____

VI. ANY ALLERGIES TO DRUGS, MEDICINES or LATEX? YES NO
If YES, please name drugs and describe reaction_____

_____

NAME:_____ DATE:_____

PATIENT QUESTIONNAIRE

PATIENTS NAME_____ DATE_____

1. WHAT PROCEDURE(S) ARE YOU INTERESTED IN?_____

_____

2. HOW LONG HAVE YOU BEEN THINKING ABOUT THIS?_____

_____

3. HAS ANYTHING HAPPENED RECENTLY TO STIMULATE YOUR INTEREST IN HAVING THIS DONE?_____

_____

4. WHAT DO YOU EXPECT THIS SURGERY TO DO FOR YOU?_____

_____

5. HAVE YOU DISCUSSED THIS WITH YOUR: ( ) SPOUSE ( ) FAMILY
( ) FRIENDS

WHAT WAS THEIR OPINION? ( ) VERY SUPPORTIVE ( ) AGAINST IT
( ) SUPPORTIVE ( ) VERY MUCH AGAINST IT
( ) UNCOMMITTED ( ) OTHER

_____

6. HAVE YOU EVER SEEN ANOTHER DOCTOR ABOUT THIS? ( ) YES ( ) NO
IF YES...WHAT HAPPENED WITH THIS DOCTOR?_____

_____

7. WHEN ARE YOU THINKING OF HAVING THIS DONE?
( ) A.S.A.P. ( ) 1-3 WEEKS ( ) 4-8 WEEKS ( ) 2-6 MONTHS

_____

8. WHAT (IF ANY) ARE YOUR CONCERNS ABOUT HAVING THIS SURGERY?

_____

_____

9. HAVE YOU EVER HAD ANY OTHER PLASTIC SURGERY PROCEDURE?
( ) YES ( ) NO...IF YES...WHAT HAVE YOU HAD DONE AND WHEN?

_____

10. WHAT IS IT THAT YOU'RE LOOKING FOR TO HELP YOU DECIDE ON THE DOCTOR, STAFF AND FACILITY TO DO YOUR SURGERY?

( ) QUALITY ( ) SAFETY ( ) RESULTS ( ) HOSPITAL ENVIRONMENT
( ) GUIDANCE ( ) TRUST ( ) EXPERIENCE ( ) BOARD CERTIFICATION
( ) FINANCING ( ) PRICE ( ) CONFIDENCE ( ) SUPERIOR FACILITIES
( ) REPUTATION ( ) CONVENIENCE ( ) _____

11. HOW WILL YOU PAY FOR THE SERVICES RENDERED?
( ) CASH ( ) CHECK ( ) CREDIT CARD ( ) FINANCING PAYMENT PLAN
( ) OTHER_____

_____

12. HOW MUCH DO EXPECT TO PAY FOR THIS SURGERY? _____