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	
TB, Persistant cough, High risk TB Occupation, out of the country, or positive TB chest X-Ray.	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? _____