



# ANNE PELED, MD

## GENERAL HISTORY FORM

**IF THIS IS YOUR FIRST VISIT, PLEASE TAKE THE TIME TO FILL THIS FORM OUT COMPLETELY.**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 E-mail address: \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_  
 Emergency Contact Cell Phone: \_\_\_\_\_ Emergency Contact relationship to you \_\_\_\_\_  
 Social Security#: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Reason for today's visit: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

How Did You Hear About Us? \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

### **PAYMENT OPTIONS:**

- MasterCard & Visa are accepted
- Personal checks are accepted at least 14 days prior to surgery



# ANNE PELED, MD

Do you currently have any of the following conditions?

	YES	NO		YES	NO		YES	NO
<b>EYES</b>			<b>ENDOCRINE</b>			<b>GENITOURINARY</b>		
Cataract(s)	<input type="checkbox"/>	<input type="checkbox"/>	Insulin dependent diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pain w/ urination	<input type="checkbox"/>	<input type="checkbox"/>
Visual disturbance(s)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes controlled with pills	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder infection	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes controlled with diet	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone(s)	<input type="checkbox"/>	<input type="checkbox"/>
Retinal problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
<b>EAR, NOSE, THROAT</b>			Parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus drainage	<input type="checkbox"/>	<input type="checkbox"/>	<b>CARDIAC</b>			<b>MUSCULOSKELETAL</b>		
Nasal breathing issues	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Swelling	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESPIRATORY</b>			Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Herniated disk	<input type="checkbox"/>	<input type="checkbox"/>
Use oxygen at home	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Back pain/injury	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<b>NEUROLOGIC</b>		
<b>GASTROINTESTINAL</b>			Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chronic nausea	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac bypass	<input type="checkbox"/>	<input type="checkbox"/>	TIA (AKA "minor stroke")	<input type="checkbox"/>	<input type="checkbox"/>
Chronic vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac catheterization	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<b>SKIN</b>		
Black/bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	<b>HEME/LYMPH</b>			Moles	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Recent lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>	Poor scarring	<input type="checkbox"/>	<input type="checkbox"/>
Gall stones	<input type="checkbox"/>	<input type="checkbox"/>	Chronic lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>			
Hernia(s)	<input type="checkbox"/>	<input type="checkbox"/>						
Spleen problems	<input type="checkbox"/>	<input type="checkbox"/>						

## PAST MEDICAL HISTORY:

Have you ever had any of the following?

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer (other)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

If yes to any of the above, please describe the condition: \_\_\_\_\_

\_\_\_\_\_

## PAST SURGICAL HISTORY (including cosmetic surgery):

Please list any previous surgery with approximate dates:

Procedure	Date	Procedure	Date



# ANNE PELED, MD

## FAMILY HISTORY:

Do you have **family members** with any of the following conditions:

Breast Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Issues	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes to any of the above, please describe the condition and identify your relation to the family member:

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## MEDICATIONS:

Please list any prescription, non-prescription, and herbal medications you are taking along with doses. If you have a long list, please bring it to us.

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**DRUG ALLERGIES:** \_\_\_\_\_

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## SOCIAL HISTORY:

Marital Status: \_\_\_\_\_ Spouse/Partner's name \_\_\_\_\_

Are you currently employed? yes \_\_\_ no \_\_\_ If so, what do you do? \_\_\_\_\_

Do you smoke? yes \_\_\_ no \_\_\_ If so, how many packs per day? \_\_\_\_\_

If you smoked in the past, when did you quit? \_\_\_\_\_

On average, how many alcoholic drinks do you have per week? \_\_\_\_\_

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# ANNE PELED, MD

## **OFFICE & INSURANCE BILLING AUTHORIZATION AND NOTIFICATION**

By my signature below, I am authorizing ANNE PELED, MD to bill my insurance company for services provided if applicable. Occasionally, insurance companies send the insured party (yourself) reimbursement directly for medical services provided by their doctors. In such an event, any monies received directly by me for services rendered by Dr. Peled will be forwarded to this office within 2 weeks of receipt. In addition, any co-pays or deductibles will be paid in full within 2 weeks of any procedure or office visit as applicable. Finally, I understand that Dr. Peled may or may not be a participating provider with my insurance plan. As such, the allowed amount according to my insurance company for any services/procedures rendered may be less than the amount charged by ANNE PELED, MD and I acknowledge that the difference will be my responsibility. I further acknowledge that any questions regarding these matters have been answered by Dr. Peled and/or her staff.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If not signed by patient, please indicate relationship to patient (e.g., spouse)

\_\_\_\_\_  
Relationship



# ANNE PELED, MD

## **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**

By my signature below, I acknowledge that I have been presented with a copy of Anne Peled, MD's 'Notice of Privacy Practices' (ask Juliette for a paper copy; they are always also available online at this address: <http://www.annepeledmd.com/forms.html>), detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of these 'Practices', and I request the following restriction(s) concerning the use of my personal medical information:

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Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

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

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Printed Name

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Signature

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Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

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Relationship



# ANNE PELED, MD

## **PHOTOGRAPHIC CONSENT**

I hereby grant permission for the use of any of my photographic medical records including illustrations, images, and/or other imaging records to Dr. Anne Peled. I understand that Dr. Peled will use these images solely for the purposes of (a) educational presentations/lectures to other physicians; and (b) discussions with potential future patients and on the practice website ([www.annepeledmd.com](http://www.annepeledmd.com)) to give potential patients and their friends and families information on some of the possible outcomes of plastic surgery. All identifiable characteristics, except for a full-face photograph or photograph of a uniquely identifiable characteristic (which may be necessary in the case of a facial procedure) will be omitted to protect patient privacy. I also understand that I may withdraw this permission or limit it at any time by giving Dr. Peled written notice specifying the images I no longer want her to use (or that I do not want any of my images used). Dr. Peled will discontinue use of the designated images within 15 business days of receiving the written notice.

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Patient Signature

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Print Name

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Date



ANNE PELED, MD

**AMERICAN BOARD OF PLASTIC SURGERY RELEASE FORM**

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use **in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.**

The Board requires that all identifiable characteristics, except for a full-face photograph or photograph of a uniquely identifiable characteristics, be blanked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy.

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Patient Signature

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Date



# ANNE PELED, MD

## HIPAA Authorization Form for Family Members/Friends

I, \_\_\_\_\_, give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):

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Relationship:

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### **Health Information to be Disclosed** (Check all that apply):

- My complete health record (including but not limited to diagnosis, lab test, prognosis, treatment, and billing, for all conditions) OR
- My complete health record, as above, with the exception of the following information:
  - (Check as appropriate):
  - Mental Health Records
  - Communicable Disease (Including HIV/AIDS)
  - Alcohol/Drug Abuse Treatment

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- All past, present, and future periods, OR
- Date: \_\_\_\_\_

Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

\_\_\_\_\_  
Name of Patient Giving Authorization

\_\_\_\_\_  
Signature of Patient Giving Authorization

\_\_\_\_\_  
Date