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

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Do **you currently** have any of the following conditions?

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

PAST MEDICAL HISTORY:

Have **you ever** had any of the following?

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

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

Breast Cancer	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No
Other Cancer	❑ Yes	❑ No	Stroke	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No
Bleeding Issues	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Depression	❑ Yes	❑ No

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

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.

_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____

DRUG ALLERGIES:_____

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? _____

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:

_____

_____

_____

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

_____
Printed Name

_____ _____
Signature Date

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

_____
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) 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.

_____

Patient Signature

_____

Print Name

_____

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):	Relationship:
_____	_____
_____	_____
_____	_____

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