Siamak Agha-Mohammadi MD PhD FACS
Plastic Surgery Body Contouring Center
Ph: 949-644-2442 Fax: 949-644-2402

Date: _____

Name: _____ Age: _____ DOB: _____/_____/_____

Address: _____ Home Tel: (_____)_____

City _____Zip_____ Wk Tel: (_____)_____

Email: _____ Cell: (_____)_____

Referring Physician: _____ Primary Care Physician (PCP):_____

SS# _____ (PCP) Phone Number: _____

Employer _____ Address _____

Occupation: _____ Marital Status: _____

Primary Insurance Co. _____ Policy # _____

Group # _____ Name of person insured _____ SS# _____

Eligibility Phone # _____ Copay _____

Secondary Insurance Co. _____ Policy # _____

Group # _____ Name of person insured _____ SS# _____

Eligibility Phone # _____ Copay _____

How did you hear about Dr. Agha? _____
Have you been to our website? _____ Was our website helpful? ☐No ☐Yes

What is the reason for your visit today? (Circle all applicable procedures below)

Nose & Face	Breast & Body	Body
Rhinoplasty Brow Lift Face Lift Neck Lift Eyelid Surgery Facial Implants Chin Surgery Lip Augmentation Other_____	Breast Augmentation Breast Augmentation with Breast Lift Breast Reduction Correction of Tubular Breasts Correction of Breast Asymmetry Breast Lift Breast Reshaping after Weight Loss	Liposuction Tummy Tuck Mommy Makeover Arm Lift Thigh Lift Lower Body Lift Brazilian Buttock Lift Buttock Enhancement Post-Bariatric Body Lift

Have you consulted with other physicians about procedure(s) indicated above: ☐No ☐Yes
If Yes, please describe your understanding of the procedure(s)_____
What is your "ideal time frame" for procedure(s) completion?_____

HEALTH INFORMATON

Age _____ Weight _____ Height _____ B/P _____ (taken in office)

Personal Past History:
Do you have any chronic medical problems? (Circle all that apply)

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
	Asthma	Other _____

Is there a personal or family history of anesthetic complications? ☐No ☐Yes

If Female, could you be pregnant? ☐**No** ☐**Yes**
Previous history of breast masses? ☐**No** ☐**Yes**
Number of live births_____
Number of pregnancies _____
Date of last breast ultrasound/mammogram _____
Date of date of menses (period)_____

Please list all prior operations:	Date	Surgeon
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Family History:
Do you have a family history of any medical problems? (Circle all that apply) Please indicate family member.

High Blood Pressure	Diabetes	Cancer
Heart Disease	Breast Cancer	Bleeding Problems
Clotting Disorders	Other	

Please list **ALL medications** and/or dietary supplements including:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)
_____

Please list **ALL allergies** and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc).

_____

Social History:
Do you smoke? ☐No ☐Yes If yes, how long?_____ how much?_____
If you are a former smoker, state the year you stopped: _____
Are you current using Nicotine Gum, Patch, or any other type of stop-smoking aid: ☐No ☐Yes
Alcohol Consumption: _____

Review of Systems:
Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure	Y ___	N ____
Heart Attack	Y ___	N ____
Angina/chest pain	Y ___	N ____
Heart bypass surgery	Y ___	N ____
Heart Failure	Y ___	N ____
Irregular Heartbeat	Y ___	N ____
Heart Murmur	Y ___	N ____

NEUROLOGICAL

Stroke	Y ___	N ____
Seizures	Y ___	N ____
Fainting	Y ___	N ____
Dizziness	Y ___	N ____
Headache	Y ___	N ____
Double Vision	Y ___	N ____

ENDOCRINE

Diabetes	Y ___	N ____
Thyroid Disease	Y ___	N ____
Taken Steroids	Y ___	N ____

HEMATOLOGIC/ONCOLOGIC/

Bleeding Tendency	Y ___	N ____
Easy Bruising	Y ___	N ____
Anemia	Y ___	N ____
Sickle Cell Disease	Y ___	N ____
Blood clots in legs/lungs	Y ___	N ____

URINARY/REPRODUCTIVE

Kidney Disease	Y ___	N ____
Urinary Disease	Y ___	N ____

EYES

Cataracts	Y ___	N ____

RESPIRATORY

Abnormal Chest X-ray	Y ___	N ____
Asthma	Y ___	N ____
Bronchitis	Y ___	N ____
Emphysema	Y ___	N ____
Recent Chest Infection	Y ___	N ____
Shortness of Breath	Y ___	N ____
Cough	Y ___	N ____

PSYCHIATIC

Depression	Y ___	N ____
Anxiety	Y ___	N ____
Psychiatric Care	Y ___	N ____
Obsessive Compulsive Disorder	Y ___	N ____

MUSCULOSKELETAL

Sciatica	Y ___	N ____
Herniated disc	Y ___	N ____
Arthritis	Y ___	N ____
Rheumatoid	Y ___	N ____
Neck, Back, Arm, Leg Problems	Y ___	N ____

INFECTIOUS/ GASTROINTESTINAL

Heartburn	Y ___	N ____
Jaundice	Y ___	N ____
Hepatitis	Y ___	N ____
Ulcers	Y ___	N ____
Hernias	Y ___	N ____

SKIN

Melanoma	Y ___	N ____
Staph Infection	Y ___	N ____
Basal cell skin cancer	Y ___	N ____
Glaucoma	Y ___	N ____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Siamak Agha, M.D., Professional Corporation, all Medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability be such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian Date

_____ _____

Patient's Signature Date

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Notice of Privacy Practices

To our patients –

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy -

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances –

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement officer.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To a federal official for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information –

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychological notes. You must submit your request in writing.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Siamak Agha, M.D. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for used and disclosures that are not identified by this notice or permitted by applicable law.

I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practices by Siamak Agha, M.D.

Name of Patient (Please Print) _____

Signature of Patient _____

Date _____

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We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcomes of their treatments. We also recognize that in these instances, a patient has every right to pursue legal action if he/she feels we have been negligent in some way. We respect every patient's right to do so.

While some healthcare legal claims are justified, there are also frivolous legal claims filed in our country—claims that are driving up insurance rates and impacting court decisions for the patients who truly deserve compensation. We believe that an agreement early in the treatment process regarding the use of board-certified experts will help expedite resolution of concerns.

OUR COMMITMENT TO YOU
We commit to using only American Board of Medical Specialties (ABMS) board-certified expert medical witness (es) in any legal situation, who follow the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics.

We demonstrate this commitment to you with our signature on this form.

WHAT WE ARE ASKING YOU TO DO
We are asking you or any representative to commit to this process also, by using only board-certified physicians expert medical witness (es) if you are dissatisfied with your medical care and decide on legal action.

We hope, and believe, you will never have to consider this again. But if you do, we will honor this commitment to you.

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PLEASE READ CAREFULLY
AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____
"Physician" shall be understood to mean Dr. Siamak Agha of Siamak A Mohammadi MD Inc.

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Society of Plastic Surgery.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the American Society of Plastic Surgery and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and Patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____ _____
Physician Patient/Guardian

_____ _____
Effective from Date of Treatment: Date of Signature