



# Mokhtar Asaadi M.D. F.A.C.S.

## PLASTIC SURGERY

(Please complete all items & please print)

### PATIENT INFORMATION:

### DATE:

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email Address \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Married  Single  Widow(er)  Divorced  Separated

Patient's Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Family Internist/Pediatrician \_\_\_\_\_ Address \_\_\_\_\_

**Patient Referred By** \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Has this office previously treated any member of your family? \_\_\_\_\_ Whom? \_\_\_\_\_

### FINANCIAL RESPONSIBILITY

My bill will be paid by:  Patient  Spouse  Father  Mother  Workmen's Comp.  No Fault  Other (specify) \_\_\_\_\_

Name of Spouse/ Parent \_\_\_\_\_ Spouse/Parent's Occupation \_\_\_\_\_

Spouse/Parent's Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

Business Phone \_\_\_\_\_ Ext. \_\_\_\_\_

If other, name and address \_\_\_\_\_

### HEALTH INSURANCE

Blue Shield: Yes  No  I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

If out-of-state, name and address of plan \_\_\_\_\_

Medicare: Yes  No

Medicaid: Yes  No

Other: (specify name, address & policy #, etc.) Include Spouse's

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

### WHERE AN ATTORNEY IS INVOLVED

Attorney's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**DESCRIBE WHAT BRINGS YOU HERE**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IF INJURY, DATE \_\_\_\_\_ AT WORK? (Describe) \_\_\_\_\_

MOTOR VEHICLE? \_\_\_\_\_ Driver  Passenger  Pedestrian

(Describe) \_\_\_\_\_

Were you treated by another doctor or at a hospital for this injury? \_\_\_\_\_ (Describe) \_\_\_\_\_

**PAST MEDICAL HISTORY**

Height \_\_\_\_\_ Present Weight \_\_\_\_\_

Any significant weight loss in the past year? Yes  No  If Yes, how much? \_\_\_\_\_

**PREVIOUS SURGERY/HOSPITALIZATIONS** (Please list **ALL**)

DATE	SURGERY/ILLNESS	DOCTOR & HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**SERIOUS INJURIES**

DATE	SURGERY/ILLNESS	DOCTOR & HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ALLERGIES:** (please list all including drugs, food, seasonal) \_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS/DRUGS:** (please list **ALL** you are now taking including birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, steroid medications, cortisone, blood thinners, aspirin, bufferin, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU EVER BEEN PREGNANT? YES  NO  HOW MANY TIMES? \_\_\_\_\_

ARE YOU PREGNANT NOW? YES  NO  HOW MANY CHILDREN DO YOU HAVE ? \_\_\_\_\_

ARE YOU PLANNING MORE CHILDREN? YES  NO

DO YOU SMOKE? YES  NO  (describe) \_\_\_\_\_ HOW MUCH PER DAY \_\_\_\_\_

ALCOHOL CONSUMPTION \_\_\_\_\_ HOW MUCH PER DAY/WEEK \_\_\_\_\_

CONSUMPTION OF COFFEE/TEA/CAFFEINATED BEVERAGES \_\_\_\_\_

HOW MUCH PER DAY/WEEK \_\_\_\_\_

DO YOU HAVE OR HAVE YOU HAD ANY SIGNIFICANT EMOTIONAL PROBLEMS? YES  NO  (describe) \_\_\_\_\_

HAVE YOU EVER HAD PSYCHIATRIC / PSYCHOLOGIC CARE? YES  NO  (describe) \_\_\_\_\_

HAVE YOU EVER BEEN ADVISED TO SEE A PSYCHIATRIST? YES  NO  BY WHOM? \_\_\_\_\_

DO YOU TAKE ANY MIND ALTERING DRUGS? YES  NO  (describe) \_\_\_\_\_

HAVE YOU HAD ANY ILLNESSES OR DISORDERS OF THE FOLLOWING? (Circle if YES)

- |  |                        |                             |                                     |                   |
|--|------------------------|-----------------------------|-------------------------------------|-------------------|
| BRAIN<br>(including strokes<br>Epilepsy) | FACE<br>(paralysis)    | LUNGS<br>(including Asthma) | INTESTINES/BOWELS                   | BLOOD             |
| BONES OR JOINTS                          | ARMS OR LEGS           | NOSE, SINUS, THROAT         | EYES<br>(including tearing/dryness) | LIVER             |
| HEART OR BLOOD<br>VESSELS                | REPRODUCTIVE<br>SYSTEM | BREASTS                     | EARS<br>(including deafness)        | STOMACH           |
| URINARY SYSTEM                           | NERVOUS SYSTEM         | ENDOCRINE OR<br>DIABETES    | SKIN                                | BLOOD<br>PRESSURE |

IF CIRCLED, PLEASE EXPLAIN: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS (Please Sign)**

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH \_\_\_\_\_ AND ASSIGN

(Insurance Company)

DIRECTLY TO MOKHTAR ASAADI, M.D., F.A.C.S., P.A. ALL SURGICAL AND / OR 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 IN INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_ - \_\_\_\_\_

(TO BE USED ONLY IN THE EVENT PAYMENT IS NOT MADE PRIOR TO SURGERY, I.E. SECONDARY OR EMERGENCY SURGERIES).

SIGNATURE OF PATIENT/PARENT/GUARDIAN \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_