Please print all information. -- PHOTO Today's Date________________ **Scanned** ☐

LAST | | | | | | | | | | | | | **FIRST** | | | | | | | | |

Sex: M ______ **F** ______ **AGE** ________ **Birth date** MONTH ____ - DAY ____ - YEAR ________

Please FOLLOW us on FACEBOOK & INSTAGRAM

Street Address ____________________________________ **Apt#**_______**City** ____________**State**__________**Zip** ________

Cell Phone #_____________________ **Home Phone :**_____________________ **Work Phone** ______________________

E-MAIL Address: Primary *Language:*

You are granting permission to use your e-mail/& or text message for emergency contact, educational material, office specials, communications and promotions. Your e-mail, or cell# will not be distributed to 3rd parties. We respect your privacy.

Social Security # ___ - __ - ____ **M**arried__ **S**ingle__ **D**ivorced__ **W**idowed__ **O**ther__

INSURANCE INFORMATION: **Name of Insurance** ______________________________________

Name of Policy Holder ____________________________ **Birth date** __ - __ - ____

Sex: M ______ **F**______ **Relation to insured** _________________

INSURANCE ID | | | | | | | | | | | | | **Group#:**

Other Insurance (MA#)_________________________Co-pay $ _____Co-Insurance %_____Deductible $________

*Authorization#*____________________ *From* ________________ *To* ________________ *# of visits* _________

CREDIT Card ***Exp: /*** ***CVV#*** ***for any outstanding balances, including: deductible, co pays, non-covered medical expenses, cosmetic services/ procedures, supplies, etc.***

Patient's **O**ccupation ___________________________**N**ame of **E**mployer____

Spouse's **N**ame_____________________**O**ccupation _________________________**W**ork Phone_________________

Name of **F**amily **D**octor ______________________________ **D**octor's **P**hone # ______________________________

How did you find us? ***☐ Google ☐ Internet ☐ U-Tube ☐ Insurance website ☐ Friend ☐Other*** _________

Do we have your permission to leave message on your answering machine at home? **Y** _____ **N** ______ __

May we discuss your condition with any member of your household? **Y**__ **N**___ **W**hom? _______________ Relationship ________________

Past or present general health good? **Y**es___ **N**o___ Are you now PREGNANT?________________

Have you ever had any of the following: (please circle) Cancer, Diabetes, High or Low blood pressure, glaucoma, rheumatic fever, fainting, ulcer, anemia, Bleeding Tendency, Seizures, tuberculosis, phlebitis, deep vein clot, hepatitis, bladder, heart, lung, liver or kidney problems, SURGERY or COSMETIC SURGERY? Do you have any **artificial joints or valves**, or PACEMAKER? Do you suntan? **Y**es____ **N**o ____ Do you use tanning salon? **Y**es___ **N**o___

Do you use alcohol or tobacco / Recreational drugs? Are you vegetarian? Had Flu shot? Pneumonia vaccine?___________

ALLERGIC to any medication? **Y**es___ **N**o___ If yes, List____

Any FAMILY HISTORY OF MELANOMA? **Skin cancers, other cancers?** _

List all CURRENT MEDICATIONS (including over the counters) ____

Nature of your skin problem and location____

How long has it been present? What have you treated it with?

I understand and agree that if necessary a **biopsy or similar procedures (excision, laser,etc.)** will be performed using an anesthetic and the material will be sent to a laboratory, and a **scar** may form at the treatment site, and that in general, **any procedure performed on skin carries a risk of scarring or discoloration which may be permanent. Infection, pain, redness, change in sensation may rarely occur.**

I request that **payment of any authorized medical** benefits be made to me or on my behalf to Dr. Eliot Y. Ghatan for medical services provided by him. ***I accept financial responsibility for all non-covered / cosmetic procedures not covered by my insurance***.

I authorize Dr. Ghatan to release any information pertaining to medical/surgical care; history treatment provided to me as insurance carriers as may be appropriate to process such claims.

I understand that this authorization and request for payment may be furnished to any agency or insurance carrier on request; it will be retained as part of my medical record, and it will be binding upon my heirs, executors, etc. of my estate.

HIPPA PRIVACY NOTIFICATION: I understand treat, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can & will be used to: 1-Conduct, plan & direct my treatment and follow up among the multiple health care providers who may be involved in that treatment directly & indirectly. 2-Obtain payment from 3rd –party payers. 3- Conduct normal healthcare operations such as quality assessments & physician certifications.

I have received, read and understand you're "Notice of Privacy Practices" containing a more complete description of the uses & disclosure of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions but if you do not agree then you are bound to abide by such restrictions.

I further consent to **photographing** for medical purposes.

Are you interested in any of our *cosmetic procedures*? ˪ Yes ˪ N0 ˪ WRINKLE REMOVAL, LARGE PORES

˪ BOTOX ˪ CHEMICAL/laser PELL ˪ Fat removal ˪ FILLERS (RESTYLANE/RADIASSE,etc) ˪ LIPOSUCTION
˪ Snoring treatment ˪ Skin tightening ˪ 4D Facelift ˪ Stretch Mark removal ˪ ED treatment
˪ LASER REJUVINATION ˪ BROWN & RED SPOTS ˪ SPIDER VEINS ˪ LASER HAIR REMOVAL

This form was reviewed by Dr. Ghatan

Signature: of the Patient:	**Witness:**