TANSAVATDI
COSMETIC & RECONSTRUCTIVE SURGERY

696 Hampshire Rd. Suite 170
Westlake Village, CA 91361
P (877) 278-0280
drt@facesbydrt.com
www.facesbydrt.com

Patient Intake Form

First Name: _____ M.I. _____ Last Name: _____ Date: _____

Date of Birth: _____ /_____ /_____ Gender *(Check One)*: Female ❑ Male ❑ Ethnicity: _____

Marital Status *(Check One)*: Single ❑ Married ❑ Widowed ❑ Divorced ❑ Social Security: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #_____ Cell Phone #_____ Cell Provider: _____

Email Address: _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone #_____

Emergency Contact

Name: _____ Relationship: Spouse ❑ Parent/Guardian ❑ Other: ❑

Home Phone #_____ Cell Phone #_____ Work Phone #: _____

Primary Insurance: *(skip this section if you have your insurance card with you - we will take a photo-copy)*

Name: _____ Policy #_____ Group ID: _____

Address: _____ City: _____ State: _____ Zip Code:_____

Secondary Insurance:

Name: _____ Policy #_____ Group ID: _____

Assignment & Release

I, _____ have insurance coverage and assign 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. 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 or Guardian: _____ Date: _____

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Tell us how you selected our office:

We are so happy to see you!

- ❑ Search Engine: Google / Bing / Yelp / Real Self
- ❑ Magazine
- ❑ www.facesbydrt.com
- ❑ Existing Patient Name: _____ *(information is confidential)*
- ❑ Family Member of Friend who is not a patient
- ❑ Physician, Name: _____
- ❑ Other: _____

Interests:

Which of the following procedures interest you? (check all that apply):

❑ Chin Implant	❑ Cheek Implants	❑ Laser Treatment
❑ Liposuction / Face	❑ Face or Neck Lift	❑ Protruding Ears
❑ Scar Revision	❑ Lip Augmentation	❑ Eyelids
❑ Botox	❑ Wrinkle Fillers	❑ Facial Fat Grafting
❑ Rhinoplasty (nose)	❑ Chemical Peel	❑ Removal of Cysts/Moles
❑ Liquid Facelift	❑ Forehead Lift	❑ Other: _____

Have you consulted other physicians concerning this? ❑ Yes ❑ No

Is having surgery your idea or someone else's?_____

Why have you decided to have it done at this time? _____

_____

_____

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Medical History and Physical

Height: _____ Weight: _____ Age: _____

Primary Care Physician Name: _____ Phone # _____

Specialty Care Physician Name: _____ Phone # _____

Date of Last Complete History & Physical: _____ EKG: _____

Chest X-Ray: _____ Blood Work: _____

Pharmacy: _____ Location: _____ Phone #_____

Allergies *(please list all allergies including latex, tape, and food)*:

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Allergic to: _____ Reaction: _____

Medications *(please list all medications, prescriptions, over-the-counter or herbal remedy & dose; ex: 5 mg twice a day)*:

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Vitamins: _____ Dose: _____

Vitamins: _____ Dose: _____

Herbal Supplements: _____ Dose: _____

Herbal Supplements: _____ Dose: _____

Regular Aspirin / Ibuprofen use: Yes ❑ No ❑

Have you ever had/or currently have *(check all that apply)*:

□ High Blood Pressure
□ Heart Disease
□ Stroke
□ Thyroid Disease
□ Cancer
□ Anxiety Disorder
□ Skin Diseases
□ Leg Swelling
□ Bruising easily
□ Dizziness or Fainting
□ Gynecological problems
□ Seasonal Allergies
□ Obstructive sleep apnea
□ Diabetes: If yes, □ medication □ insulin or □ none
□ High Cholesterol
□ Angina
□ Mental Illness
□ Back Problems
□ Muscle / Nerve disease
□ Chronis Bronchitis
□ Asthma
□ Bleeding Tendencies
□ Blood Clots
□ Gastric Reflux/Heartburn
□ Hepatitis
□ Shortness of breath
□ Use CPAP Machine
□ Chest Pain
□ Irregular Heartbeat
□ Depression
□ Neck Problems
□ Emphysema
□ Kidney Disease
□ Migraines
□ Ulcers
□ Seizures
□ Glaucoma
□ Anemia
□ Snore loudly
□ HIV / AIDS

Female Patients:

Age: _____ Last period: _____ Do you take oral contraceptives or hormone replacement? Yes ❑ No ❑

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Family History

Does anyone in your family have a history of *(check all that apply)*:

□ Diabetes
□ Arthritis
□ Stroke
□ Hypertension (High blood pressure)
□ Heart Disease
□ Lung problems
□ Kidney problems
□ Bleeding disorders
□ Liver problems
□ Muscle or neuromuscular disorder
□ Malignant hyperthermia
□ Clotting problems
□ High temperature after exercise
□ Breast cancer
□ Other _____

Surgical History

What surgeries have you had?

Cosmetic: _____

Non-Cosmetic: _____

Have you ever had anesthesia? Yes ❑ No ❑

If yes, did you have any serious problems? _____

Indicate the type(s) of anesthesia received in the past, listing any complications/reactions you experienced:

Local Anesthesia: _____

General Anesthesia: _____

Spinal/epidural: _____

Do you have a family history of unexpected death following general anesthesia or exercise? Yes ❑ No ❑

Previous nausea and/or vomiting with surgery? Yes ❑ No ❑

Have you ever had motion sickness? Yes ❑ No ❑

Do you have a personal history of *(check all that apply):*

□ Muscle spasm
□ Dark or chocolate colored urine
□ Easy bleeding or bruising
□ Unanticipated fever following anesthesia or serious exercise
□ Scarring problems with surgery

Skin History

Describe your history of:

Sun Exposure: _____ Skin Cancer: _____ Acne: _____

Have you ever had Accutane treatment: _____ Other skin problems: _____

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Social and Personal

Do you exercise regularly? Yes ❑ No ❑
_____/week or _____/month

Cortisone Injection in the past year? Yes ❑ No ❑
Dosage & Frequency: _____

Have you ever used tobacco? Yes ❑ No ❑
If yes, average # packs per day? _____
Number of years smoking: _____ Years quit:_____

Do you drink alcohol? Yes ❑ No ❑
If yes, how many drinks per week? _____

Ever used LSD / Speed / Cocaine / Marijuana?
Yes ❑ No ❑ When? _____

Recent weight change? Yes ❑ No ❑
If yes, ❑ Increase (up) OR ❑ Decrease (down)

Mental Health

Is stress a major problem for you? Yes ❑ No ❑

Do you feel depressed? Yes ❑ No ❑

Do you panic when stressed? Yes ❑ No ❑

Do you have any problems with eating / your appetite? Yes ❑ No ❑

Do you cry frequently? Yes ❑ No ❑

Have you ever attempted suicide? Yes ❑ No ❑

Do you have trouble sleeping? Yes ❑ No ❑

Have you ever been to a counselor? Yes ❑ No ❑

Have you ever taken psychiatric Medication(s)? Yes ❑ No ❑

Do you currently take psychiatric Medication(s)? Yes ❑ No ❑

Should you have cosmetic surgery, please explain how you anticipate your life being different after the procedure?_____
_____
_____

BY SIGNING THIS FORM, I ATTEST THAT THE ABOVE MEDICAL INFORMATION IS ACCURATE, AND I HAVE DISCLOSED ALL INFORMATION HONESTLY.

Signature: _____ Date: _____

Financial Responsibility

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default.

Signature: _____ Date: _____

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Consent to Communicate

Full Patient Name: _____

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Contact *AM/PM*
❑ Call Work Phone	Yes ❑ No ❑	Yes ❑ No ❑	❑	
❑ Call Cell Phone	Yes ❑ No ❑	Yes ❑ No ❑	❑	
❑ Call Home Phone	Yes ❑ No ❑	Yes ❑ No ❑	❑	
❑ Send Email	-	-	❑	-
❑ Email Appointment Reminders ❑ Email Medical Information ❑ Email Office Specials				
❑ Send Regular Mail	❑ Home Address or ❑ Other Address *(please list)*:			
❑ Send Text Messages? If so, who is your provider? ❑ AT&T ❑ T-Mobile ❑ Verizon ❑ Sprint ❑ Other				
❑ Text Appointment Reminders ❑ Text Office Specials				

If it's ok to leave a message with another person, please list them below:

Name	DOB	Relationship	OK to Release Results	Any Comments
			Yes ❑ No ❑	
			Yes ❑ No ❑	

Signature: _____ Date: _____

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Cancellation and No Show Policy

This policy has been established to help us serve you better.

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide at least a 24 hour notice. This will enable other patients to take that appointment time. Office appointments which are cancelled with less than 24 hours' notice may be subject to a cancellation fee outlined below.

Patients who do not show up for their appointment and don't call to cancel will be considered a NO SHOW. After the first no show, the patient will be subject to a fee which will be due at the time of scheduling your next appointment. Fees will increase if there is more than one NO SHOW appointment.

The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality consideration, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your practitioner.

- **A charge of $25.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hour notice is given.**
- **A charge of $50.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hour notice is given the second time.**
- **A charge of $75.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hour notice is given the third time.**
- **A pattern on non-cancelled missed appointments may result in discharge from the practice.**

Signature: _____ Date: _____

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Refund Policy

At Tansavatdi Cosmetic and Reconstructive Surgery we work with each patient to discuss treatment objectives and review likely outcomes, benefits, and risks associated with each treatment.

We offer individual treatment as well as packaged options so each patient may choose the approach that is best suited for their needs and budget.

Once services are rendered they will not be refunded, however, to ensure our patients always receive the greatest experience at Tansavatdi Cosmetic and Reconstructive Surgery, unused service balance can be applied to any other services or we can issue you a refund check of the remaining balance.

For Skin Care Products and our Makeup Line, Patients may request a refund check for products returned due to allergy, defective product or product damaged in shipment within 14 days of purchase. If dissatisfied with product performance we will allow a product exchange within 14 days of purchase.

All injectable treatment sales, including but not limited to: Botox®, Xeomin®, Dysport®, Juvederm®, Radiesse®, Restylane®, Kybella®, Belotero®, and Sculptra® are final sales.
Refunds or credit cannot be offered once any injectable treatment is completed.

Signature: _____ Date: _____

Notice of Privacy Practices Packet

The following packet describes how medical information about you may be used and disclosed; and how you can gain access to this information. Please review the packet carefully. Your signature is required on the last page to acknowledge receipt of this information.

We are here to answer any questions you might have… just ask!

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NOTICE OF PRIVACY PRACTICES

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696 HAMPSHIRE RD. SUITE 170 | WESTLAKE VILLAGE, CA 91361

Matthew Maloney | Privacy Officer | (805) 715-4996

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

❑ Parent or guardian of minor patient

❑ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

☐ Me gustaría recibir una copia del Aviso de Prácticas de Privacidad modificada por e-mail a:

_____

Firmado: _____ Fecha:_____

Imprimir Nombre: _____ Teléfono: _____

Si no está firmada por el paciente, por favor indique la relación:

❑ El padre o tutor del paciente menor de edad

☐ Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: _____