



PATIENT REGISTRATION FORM

DATE: _____ MALE _____ FEMALE _____ NEW PT: _____

MARITAL STATUS-CIRCLE ONE: M S W D NAME OF SPOUSE/PARENT _____

SOCIAL SECURITY# _____ E-MAIL ADDRESS: _____

NAME: _____ BIRTH DATE: _____ AGE _____

ADDRESS: _____ PHONE _____

CITY: _____ STATE: _____ ZIP: _____

CELLPHONE: _____ OTHER _____

OCCUPATION/EMPLOYER: _____ WORK #: _____

SPOUSE'S EMPLOYER AND ADDRESS: _____

PHONE NUMBER: _____

NEAREST RELATIVE NOT LIVING WITH YOU _____

PHONE NUMBER: _____

PERIODICALLY WE WILL SEND YOU CORRESPONDENCE VIA US MAIL, EMAIL OR CONTACT YOU BY TELEPHONE. IF YOU HAVE ANY PRIVACY CONCERNS PLEASE INDICATE THEM:

_____ **NO OBJECTIONS, PLEASE INITIAL** _____

MY TIME FRAME FOR SURGERY IS:

_____ **AS SOON AS POSSIBLE** _____ **1-3 MONTHS** _____ **3-6 MONTHS**

_____ **6-12 MONTHS** _____ **JUST NEED INFORMATION**

ARE YOU INTERESTED IN FINANCING? _____ **YES** _____ **NO**

PATIENT SIGNATURE

DATE

HAVE YOU EXPERINCED ISSUES WITH ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY:

YES	NO		YES	NO	
___	___	RECENT ILLNESS(WITHIN 1 YR)	___	___	HIGH BLOOD PRESSURE
___	___	COUGH COLD, FLU RECENTLY	___	___	HEART TROUBLE
___	___	EXCESSIVE BLEEDING	___	___	DVT HISTORY
___	___	DIABETES	___	___	PSYCHIATRIC CARE
___	___	THRYOID PROBLEMS	___	___	EXCESSUVE BRUISABILITY
___	___	BLEEDING PROBLEMS	___	___	EXCESSIVE SCARRING
___	___	DELAYED OR POOR HEALING	___	___	HEPATITIS TYPE ()
___	___	VISUAL PROBLEMS	___	___	NASAL OBSTRUCTION
___	___	LUNG DISEASE	___	___	ASTHMA
___	___	EMPYSEMA	___	___	ANEMIA
___	___	STROKE	___	___	TREATMENT OF TUMOR
___	___	HEART ATTACK	___	___	ANGINA
___	___	IRREGULAR HEART BEAT	___	___	SEIZURE OR EPILEPSY
___	___	PACEMAKER	___	___	LIVER DISEASE
___	___	CIRRHOSIS	___	___	JAUNDICE
___	___	RHEUMATIC FEVER	___	___	STOMACH ULCER
___	___	SCARLET FEVER	___	___	KIDNEY DISEASE
___	___	ARTHRITIS	___	___	ARTIFICIAL JOINTS
___	___	HIV	___	___	AIDS
___	___	HERPES	___	___	COLD SORES _____
___	___	CANCER	___	___	OTHER SERIOUS ILLNESS
___	___	TB	___	___	BLOOD VESSEL GRAFTS
___	___	UNDER CARE OF PSYCHIATRIST	EXPLAIN: _____		

DO YOU ACCEPT THE FACT THAT EVERY MEDICAL/SURGICAL TREATMENT IS ASSOCIATED WITH RISKS, POTENTIAL COMPLICATIONS AND OTHER

IMPONDERABLES? _____ YES _____ NO _____

DO YOU HAVE FREQUENT SKIN INFECTIONS, IRRITATIONS OR RASHES? CIRCLE IF SO.

ARE YOU EASILY UPSET OR IRRITATED? YES NO

DO YOU USUALLY FEEL UNHAPPY OR DEPRESSED? YES NO

MEDICATIONS: LIST ALL MEDICATIONS INCLUDING VITAMINS AND HERBAL SUPPLEMENTS:

HAVE YOU TAKEN ACCUTANE OR RECENTLY STOPPED? _____

ALLERGIES: LIST ALL MEDICATIONS THAT YOU ARE ALLERGIC TO: _____

YES/NO ARE YOU ALLERGIC TO ANY CREAMS, TAPE, MAKE-UP, LATEX ETC.

YES/NO DO YOU SMOKE OR DID YOU EVER SMOKE CIGARS OR CIGARETTES

HOW MUCH AND HOW LONG? _____

YES/NO DO YOU DRINK ALCOHOLIC DRINKS, HOW MANY PER WEEK? _____

ARE YOU PREGNANT? _____

HAVE YOU CONSULTED ANY OTHER DOCTOR ABOUT THESE PROCEDURES YES/NO

WHEN? _____

HAVE YOU HAD ANY PRIOR PLASTIC SURGERY PROCEDURES DONE YES/NO

WHAT AND WHEN? _____

WHO PERFORMED THE SURGERY? _____

WHERE YOU SATISFIED WITH THE RESULTS? YES/NO IF NOT WHY? _____

HAVE YOU HAD ANY OTHER SURGERY, OR AN INJURY, TO THE FACE, NOSE NECK OR EYES?

HOW MUCH DOWNTIME ARE YOU WILLING TO HAVE?_____

WHEN DID YOU BEGIN TO CONSIDER SURGICAL CORRECTION?_____

WHY HAVE YOU DECIDED TO HAVE YOUR PROCEDURE DONE AT THIS TIME?

HAVE YOU DISCUSSED THIS SURGERY WITH YOUR FAMILY? YES/NO

ARE THEY AGREEABLE? YES/NO IF NOT, WHAT HESITATION DO THEY HAVE?

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT COVERED BY MY INSURANCE COMPANY.

ASSIGNMENT: I PERMIT PAYMENT DIRECTLY TO AMIR M. KARAM MD, INC. FOR ANY BENEFITS DUE OR SERVICES RENDERED.

AUTHORIZATION FOR DISCLOSURE AND RELEASE OF INFORMATION:

I AUTHORIZE AMIR M. KARAM, MD TO DISCLOSE COMPLETE INFORMATION CONCERNING HIS MEDICAL FINDINGS AND TREATMENT OF THE UNDERSIGNED, FROM THE INITIAL OFFICE VISIT UNTIL THE DATE OF THE CONCLUSION OF SUCH TREATMENT, TO THOSE INDIVIDUALS WHO, IN DR. KARAM'S SOLE DETERMINATION, ARE REQUIRED TO RECEIVE SUCH INFORMATION FOR THE PURPOSE OF MEDICAL TREATMENT AND MEDICAL QUALITY ASSURANCE. AUTHORIZATION IS HERBY GRANTED FOR RELEASE OF ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM. A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL. AUTHORIZATION IS HEREBY GRANTED FOR THE RELEASE OF PERTINENT INFORMATION TO A HOSPITAL FOR APPROPRIATE CONTINUUM OF CARE TREATMENT AS REQUIRED.

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