WESTSIDE HEAD & NECK

FACIAL PLASTIC SURGERY | HEAD AND NECK SURGERY | LIPOSUCTION SURGERY | OTORHINOLARYNGOLOGY
MICHELLE A. PUTNAM, M.D. • AMANDA R. SALVADO, M.D. • DOROTHY WANG, M.D.

PATIENT INFORMATION

Name:_____
Last First Middle

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender: ☐ Male ☐ Female

Name of Spouse:_____

How do you plan to pay for this visit? ☐ Check ☐ Cash ☐ Credit Card

Address:_____ City:_____

State:_____ Zip:_____ Date of Birth:_____ /_____ /_____ Age:_____
Mo Day Yr

Social Security No:_____ Occupation:_____

Driver's License:_____ Employer:_____

Telephone: Home: ( )_____ Work: ( )_____ Cell: ( )_____

Email:_____ May we leave a message re: cosmetic services? ☐ Yes / ☐ No

Would you like to be notified by e-mail regarding specials? ☐ Yes / ☐ No

How did you hear about us? (please check all that applies, include additional information where appropriate)

☐ Friend or family ☐ Physician Referral
☐ Online: ☐ Advertising postcard or flyer **Other:** _____

EMERGENCY CONTACT

Name:_____ Relationship:_____ Telephone: ( )_____

BILLING POLICY

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

I understand that I will be fully responsible for all charges incurred while at Westside Head & Neck. I will be charged a 25% collection fee if my check is returned for any reason, or if my balance is 30 days overdue. All appointments cancelled with less than 24 hours notice will be assessed a $50 service charge.

I have read the above policies, and consent, and understand them, as well as my financial responsibility.

Signature:_____ Date:_____

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MEDICAL HISTORY PAGE-2

Do you have now or a history of (check all that apply):

- ☐ Alcohol / Drug Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer
- ☐ Clotting Disorder
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty breathing through nose
- ☐ Dry Eyes
- ☐ Easy Bruising
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ HIV/ARC/AIDS
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Nose Bleeds
- ☐ Psychiatric Illness
- ☐ Sinus Infections
- ☐ Snoring/Sleep Apnea
- ☐ Stroke

Please list current prescription & OTC medications being taken, or which have taken in the last 6 months:

_____

_____

_____

Please list vitamins/supplements/alternative medications being taken, or which have taken in the last 6 months:

_____

_____

_____

Do you have allergic reactions to any medication or other substance? ☐ Yes / ☐ No

If yes, please explain: _____

Do you have any caps, crowns, bridges or loose teeth? ☐ Yes / ☐ No

If yes, please explain: _____

Are you currently undergoing dental work? ☐ Yes / ☐ No

Have you ever had an adverse reaction to latex? ☐ Yes / ☐ No

If yes, please describe incident: _____

Have you ever had an adverse reaction to topical, local or general anesthetics? ☐ Yes / ☐ No

If yes, please describe incident: _____

Do you drink alcoholic beverages, including beer, wine, or liquor? ☐ Yes / ☐ No If quit, when? _____

(# per day / week) Beer _____ / _____, Wine _____ / _____, Liquor _____ / _____

Do you, or have you ever used tobacco? ☐ Yes / ☐ No If quit, when? _____

Do you use recreational drugs? ☐ Yes / ☐ No How frequently? _____

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MEDICAL HISTORY PAGE-3

Please list all hospitalizations & surgeries, including surgeries done for cosmetic reasons:

SURGICAL OPERATIONS

Type of Operation: Date: Surgeon / Location:

_____

_____

_____

_____

HOSPITALIZATIONS (excluding surgeries)

Reason for Admission: Date: Physician / Location:

_____

_____

_____

_____

NON-SURGICAL COSMETIC PROCEDURES

Please list any non-surgical, cosmetic procedures you've had in the past. Please include product name & where you were treated (Ex: Botox - Forehead, Chemical Peel - Face):

_____

_____

_____

Could you possibly be pregnant or are you currently breastfeeding? ☐ Yes / ☐ No

Have you ever taken Accutane? ☐ Yes / ☐ No If yes, when and for how long? _____

Have you ever had cold sores? ☐ Yes / ☐ No If yes, when was last outbreak? _____

Do you form heavy scars? ☐ Yes / ☐ No

Do you bruise easily? ☐ Yes / ☐ No

Do you have problems healing? ☐ Yes / ☐ No If yes, please describe: _____

_____

List any chronic skin conditions and treatments: _____

_____

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NON-SURGICAL COSMETIC PROCEDURES PAGE-4

Do you diet frequently? ☐ Yes / ☐ No

Are you currently on a special diet? ☐ Yes / ☐ No

If yes, please explain: _____

_____

Please describe which attributes of your physical appearance bother you most and why:

_____

_____

_____

Of the things you would like to change about your appearance, which are the most important or urgent to you?

_____

_____

_____

Would you like information about treatment for any of the following? (check all that apply)

Wrinkles
- ☐ Forehead
- ☐ Temples - Crow's feet
- ☐ Between eyebrows
- ☐ "Smile lines" around the nose & mouth
- ☐ Verticle lines around the lips
- ☐ Creases on the nose
- ☐ Chin

Skin
- ☐ Acne scars
- ☐ Age spots
- ☐ Facial veins
- ☐ Mole or skin tag removal
- ☐ Pigment problems
- ☐ Redness (Rosacea)
- ☐ Scar revision
- ☐ Unwanted facial hair
- ☐ Sun damage on neck & chest

Cheeks & Chin
- ☐ "Flat" cheeks
- ☐ Loss of volume in cheeks
- ☐ "Weak" chin
- ☐ Unwanted cleft chin

Neck & Jawline
- ☐ Face/neck laxity
- ☐ Jowls
- ☐ Jawline "too weak"
- ☐ Jawline "too bold"

Body
- ☐ Cellulite
- ☐ Excessive sweating
- ☐ Mole or skintag removal
- ☐ Stretch marks
- ☐ Unwanted hair
- ☐ Age spots or sun spots on hands/arm

Nose
- ☐ Asymmetry
- ☐ Unwanted bump or hump
- ☐ Undefined nose bridge
- ☐ Too wide
- ☐ Too narrow
- ☐ Unhappy with tip of nose
- ☐ Unhappy with nostrils
- ☐ Revision of previous rhinoplasty

Ears
- ☐ Ears "stick out"
- ☐ Earlobes stretched or torn

Lips
- ☐ Too thin or loss of volume with age

Other: _____

Are there any specific procedures or treatments you are intersted in hearing more about? _____

_____

_____

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LIFESTYLE PAGE-5

Your recovery can be influenced greatly by the emotional stresses in your life. Complications are frequently connected with apparently unrelated circumstances. The information you provide here is vitally important for medical decisions regarding your pre/post-operative treatment and care. Please answer the following questions. Add extra explanation on the back of the page if you feel a situation requires further clarification. Please gauge your stress levels in the following areas (0-10). Add extra explanation if you feel a situation requires further clarification.

_____Job or school
_____Divorce or separation
_____Death of a close one
_____Primary relationship
_____Family / Parents / Children
_____Financial
_____Other_____

What activities do you engage in to counterbalance stress in your life?_____

_____

What sort of music do you like to listen to to relax & feel comfortable?_____

Is there anyone who is against the idea of you having cosmetic surgery or procedures? ☐ Yes / ☐ No

Has anyone actively objected to you receiving treatment? ☐ Yes / ☐ No

Has anybody strongly suggested and/or insisted you have a procedure done? ☐ Yes / ☐ No

If you have answered "Yes" to any of the above questions, please explain:_____

_____

Is this procedure to correct residual effects of another procedure, as a result of an accident, or due to a surgical complication? If yes, please explain:_____

_____

Are you currently, or have you had in the past, any psychiatric or psychological treatment or therapy? ☐ Yes / ☐ No
If yes, during what years, & briefly summarize the condition or circumstances being addressed:_____

_____

PHOTO CONSENT

Before and after photographs are important evidence as to the success of your procedure / treatment. The doctors at Westside Head & Neck do not use these photographs for any purpose unless they have your permission. However, many patients who are contemplating a cosmetic procedure, find looking at before and after pictures to be very useful. For this reason, we would like to have your permission to use these photographs for patient education. Occasionally, the doctors use them for lectures or talks, to post on our website, or for marketing purposes.

I have read the above statement and allow Westside Head & Neck to use my before and after photographs for the purposes indicated above.

Signature of Patient or Legal Guardian_____ Date: _____

Patient Name or Legal Guardian (Please Print)_____

Cosmetic surgery is not covered by insurance. For reconstructive surgery, it is your responsibility to submit claims to your insurance company. We are happy to provide an itemized bill after surgery.

AUTHORIZATION FOR EXAMINATION AND TREATMENT

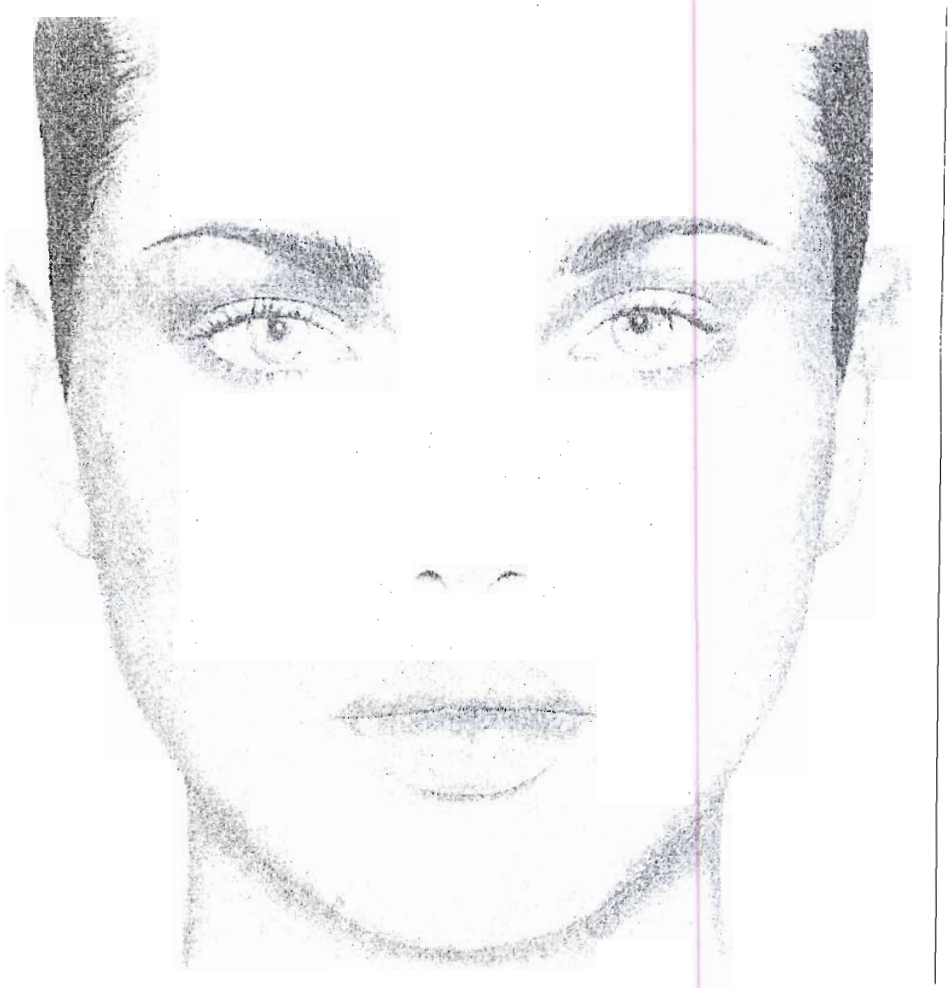
I represent to the doctors and staff of Westside Head & Neck that I am at least 18 years old, or are a legal guardian of the patient. I hereby authorize the clinical staff at Westside Head & Neck to take my medical history and perform any necessary examinations. I agree to be financially responsible for any charges incurred at Westside Head & Neck. I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I authorize any hospital, physician or any other persons who have attended to or examined me to disclose to Dr. Michelle Putnam, Dr. Amanda Salvado, Dr. Dorothy Wang, or Dr. Behrad Ayrehchi, when requested, all information concerning this illness, authorization shall be considered as effective and valid as the original.injury or medical problem. I will inform the doctors and staff at Westside Head & Neck of any changes in my health status or regarding any of the above information. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature of Patient or Legal Guardian_____ Date: _____

Patient Name or Legal Guardian (Please Print)_____

Are you interested in a Free Cosmetic Consultation with a Westside Head & Neck doctor?

On the drawing below, please mark the areas of your face in which you are not fully satisfied. (For ex: wrinkles, sagging, scars, sun spots, loss of volume, moles or skin tags, size or shape of nose, lips, ears, eyes, etc.)



Once completed, please turn this in to the front desk, and they can schedule you for your free consultation, or call (310) 204-4111. Also, be sure to sign-up for our monthly newsletters with special offers and events at www.westsidehn.com.

Name: _____

Phone Number: _____ Date: _____

Can we leave a cosmetic related message at this number? YES / NO

Westside Head and Neck Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At Westside Head and Neck, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involved in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your Insurance Company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service, in a confidential manner. We have a written contract with each business associate that requires them to protect your privacy as well.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In a medical emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new doctor owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will fax or mail your files for you. You have the right to see and receive a copy your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your requests to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. If needed, you may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office directly at (310) 204-4111.

As required by a new federal law, this notice goes into effect as of April 14, 2003. **Acknowledgement:** I have received a copy of the Westside Head and Neck, Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____
If signing as a parent or guardian, please note the name of the patient: _____