Patient Information

Name:____ Today's Date:__________________________

Address: Home____

Street *City* *State* *Zip*

Business____

Street *City* *State* *Zip*

Date of Birth: __________________ Age: ___________

Sex: (M) (F) Marital Status: S, M, D, Sep, Widowed

Occupation: ____

Employer: ____

Phone Contact:

____
Best Contact Number

____
Alternative Number

*Email address:*__________________________________

How were you referred to us?

____

Yes No Do you wish to receive our email newsletter?

Name(s) of family members who have been treated by our staff

____

What website(s) did you find helpful to use in researching our practice or the procedure?______________________________

Insurance

[We will need a copy of your insurance card for our records.]

Primary Carrier:
Insurance Carrier___________ Number_______________

Insured's Name______________________________________

Person responsible for bill___________________________

Secondary Carrier:
Insurance Carrier____________ Number_______________

Insured's Name____

Person responsible for bill______________________________

Medical History

Circle any of the following you have experienced:

Asthma	Arthritis	Venereal Disease	Other Blood Problems
Hay Fever	Arthritis therapy	AIDS / HIV	Substance abuse therapy
Nasal allergies	Steroid therapy	Frequent headache	Bouts of depression
Visual problems	Poor circulation	Excess Scarring	Nervous breakdown
Kidney trouble	Dizziness	Thyroid therapy	Psychiatric therapy
Bladder trouble	Convulsions	Frequent chest pain	Gall bladder trouble
Lung trouble	Skin infection	Paralysis	Stomach ulcers
Heart trouble	Skin irritation	Hormone therapy	Other stomach trouble
High blood pressure	Rashes	Anemia	Liver trouble/Hepatitis
Diabetes	Fever Blisters	Profuse bleeding	
Yellow Jaundice	Genital herpes	Excess bruising	

No Yes Have you ever had any surgery(s) or serious injury(s)? [Including cosmetic surgery]
Please list procedure, date and physician: ____

____

No Yes Are you now taking any medications, herbal or weight loss supplements ? Please list them:

____

____

No Yes Are you allergic to any medication, creams, tape, make-up, etc? Please describe reaction:

____

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Patient Information

No Yes Have you ever taken the drug "Acutane"? When?________________________

No Yes Do you smoke more than 10 cigarettes a day?

No Yes Do you drink more than 6 cups of coffee a day?

No Yes Do you usually drink two or more alcoholic beverages a day?

No Yes Have you or a relative ever had a blood clot or lung embolus? When?________________________

When was your last physical examination?________________________

Who is your primary care physician? ________________________ Phone Number: ________________

No Yes May we contact him/her for additional information pertaining to your health?

Women Only Date of last menstrual period? ________________

No Yes N/A Are your periods often irregular?

No Yes Have you had any "female" or GYN problems? Please explain: ________________

____

No Yes Do you have any other medical problems that have not yet been covered? Please explain:

____

Services

Please indicate which procedure(s) are you interested in:

Surgical Services:

- ❑ Rhinoplasty (nose)
- ❑ Chin Augmentation
- ❑ Facelift
- ❑ Cheek or Neck Lift
- ❑ Eyelids
- ❑ Chemical Peel
- ❑ Scar Revision
- ❑ Protruding Ears
- ❑ Removal of cysts, warts, moles etc.
- ❑ Liposuction - Please list area(s): ________________________

Skin Clinique' services:

- ❑ Botox/ Dysport
- ❑ Injectable fillers (Restylane, Juvederm, Sculptra, etc.)
- ❑ Photo facials
- ❑ Skin care
- ❑ Coolsculpting
- ❑ Chemical Peels
- ❑ Other________________________

Please write, in your own words, what condition(s) you wish to discuss ________________________

____

No Yes Do you desire improvement in both appearance and function?

No Yes Do you accept the fact that every medical and surgical treatment is associated with risk and other imponderables?

No Yes Have you received and read our information regarding the surgical procedure(s)?

No Yes Do you give consent and authorize the recommended diagnostic, medical, surgical, anesthetic, and other diagnostic services that the Center deems beneficial while you are under their care?

☐ I consent to receive text messages from the practice for appointment reminders, general information and marketing.

☐ I am aware that the practice HIPAA Privacy Policies are available on the website and in hard copy at the office for my review.

☐ I understand that Dr. Kaniff is licensed and regulated by the Medical Board of California.

Thank you. The above information you have provided is essential in our comprehensive evaluation in your case.

Patient Signature: ________________________ Date:________________

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