MAHSA SOHRAB MD

OCULOFACIAL PLASTIC SURGEON

COSMETIC PATIENT INTAKE FORM

Last Name: ________________________ First Name: ____________________ Gender: M F

Address: ____

City: ___________________________ State: _______ Zip: ________

E-mail: __________________ Home Phone: _________________ Cell Phone: ______________

Preferred method of communication:

Email Cell Phone Other: _______________

Marital Status:

Single Married Widowed

DOB: ____________

Occupation: ________________________

Student Retired Unemployed Employed

Emergency Contact:

Name: _____________________________________ Phone: __________________

Referral source:

Physician __________________________ Internet search _________________________

Friend ____________________________ Other ________________________________

Primary Care Physician:

Name: _________________________________ Phone No: _____________________________

Preferred Pharmacy: __________________________ Street/Town ________________________

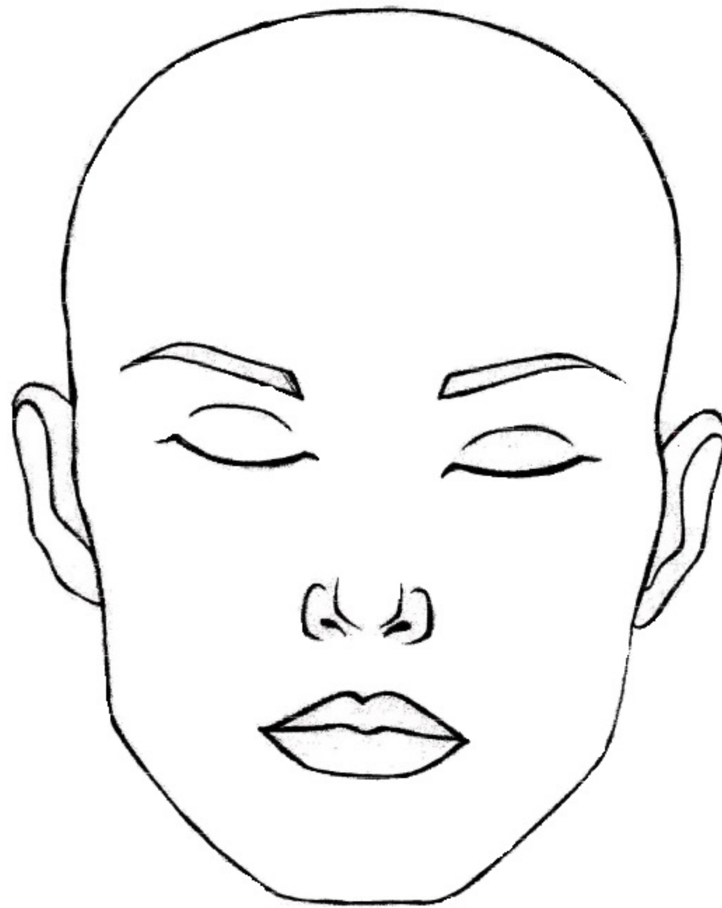
Which of the following are you interested in discussing today?

Eyelid Surgery Botox
Microneedling Skin care products/peels
Injectable fillers Other:______________________________

Have you had any of the following procedures done before?:

Eyelid surgery Facelift
Laser procedures Botox
Injectable fillers Other___________________________

Please mark any areas of concern:



HEALTH INFORMATION:

Current medications:____

Allergies to medications:____

Do you smoke: Yes ☐ No ☐ Frequency:____________________

Previous smoker: Yes ☐ No ☐

Please indicate if you have or have had any of these medical conditions:

Allergies/Hay fever ☐	Headaches ☐	Asthma ☐
Cancer ☐	Diabetes ☐	Thyroid Disorders ☐

Stomach Disorders
High blood pressure
Other heart condition
Neurological disorders
Pregnant/Nursing

Hard of hearing
Heart attack
Lung disorders
Sinus infections
Urinary Disorders

Kidney disorders
Heart stent(s)
Seizure disorders
Skin disorders

If yes to above, please describe:____

Surgical History:____

Problems with local or general anesthesia:____

COMMUNICATION RELEASE

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services offices of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes, as stated below. This waiver authorizes Mahsa A Sohrab, MD to send or receive my medical information as noted (please check box):

Leave a VOICEMAIL recording, including my personal health information, on my phone:
YES NO

Use of electronic communication systems (i.e. FAX, TEXT) to transmit prescriptions, disorder related information, lab results:
YES NO

Use of EMAIL to transmit treatment or disorder related information which may include a diagnosis, lab or other results, even if the email is not encrypted:
YES NO

CONSENT FOR PHOTOGRAPHS

I grant permission to the staff of Mahsa A Sohrab, MD to obtain photographs of me as they deem necessary to show response to treatment and to assist in treatment decisions. I understand that my photographs may be used for teaching/educational purposes.

______________________________________ ________________________________
Signature of patient or guardian Date

FINANCIAL POLICIES

Cancellation and No-Show policy:
We allow a significant amount of time for each appointment. If you do not show for an appointment, or cancel a cosmetic appointment with less than 24 hours notice, you may be subject to a $250 fee.

Surgical appointments: A $500 deposit will be taken when a cosmetic surgical appointment is scheduled. 10 days notice is required for rescheduling or cancelling of these appointments. Payment in full is required no later than 7 days prior to your surgical appointment. If payment is not received by this time, your appointment will be cancelled.

Payment Methods: We accept cash, check, and all major credit cards as forms of payment. A returned check fee of $50 will be assessed for any returned checks.

ACKNOWLEDGEMENT OF UNDERSTANDING OF POLICIES:

I have read, understood, and agree to all the above financial policies and office policies of Mahsa A Sohrab, MD. I certify that the information provided is correct to the best of my knowledge.

______________________________________ __________________________

Signature Date