



Legal Name – First: \_\_\_\_\_ Last: \_\_\_\_\_ MI: \_\_\_\_\_

Preferred Name (If different from above): \_\_\_\_\_

Street Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone: ( ) \_\_\_\_\_ Cellular: ( ) \_\_\_\_\_

Work: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: F \_\_\_\_ M \_\_\_\_

Employer: \_\_\_\_\_ Title: \_\_\_\_\_ Address: \_\_\_\_\_

In Case of Emergency Notify: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Emergency Tel #: ( ) \_\_\_\_\_

Check which applies: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Primary Care Physician: \_\_\_\_\_ Tel#: ( ) \_\_\_\_\_

Who should we thank for referring you to Dr. Kevin Sadati? \_\_\_\_\_

If you were not referred by someone, how did you hear about Dr. Kevin Sadati? \_\_\_\_\_

Please check off any procedure (s) below that you are interested in having done:

**Facial Procedures**

- ☐ Blepharoplasty Eyelid Surgery
- ☐ Brow or Forehead Lift
- ☐ Earlobe Repair or Reduction
- ☐ Facial Liposuction
- ☐ Face or Neck Lift
- ☐ Lip Enhancement
- ☐ Facial Fat Grafting
- ☐ Botox or Dysport
- ☐ Fillers; Radiesse, etc
- ☐ Otoplasty (Ear Pinning)

**Breast Procedures**

- ☐ Breast Augmentation
- ☐ Mastopexy (Breast Lift)
- ☐ Gynecomastia (Male Breast)

**ENT (nose/throat) Procedures**

- ☐ Rhinoplasty (Nose Reshaping)
- ☐ Septoplasty (Septum Work)
- ☐ Sleep Apnea
- ☐ Tonsils
- ☐ Sore Throat
- ☐ Breathing Problems

**Body Procedures**

- ☐ Buttock Lift
- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Brachioplasty (Arm Lift)
- ☐ Liposuction

**Other Procedures**

- ☐ Lesions/Moles/Skin Cancer
- ☐ Skin Care
- ☐ PRP (Platelet Rich Plasma)
- ☐ Other \_\_\_\_\_

**Please put a check mark in any of the boxes below if you have had any of the following conditions:**

Heart Disease	<input type="checkbox"/>	Glaucoma or Eye Problems	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	Bleeding Tendencies	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>
Palpitations or Heart Murmur	<input type="checkbox"/>	Hepatitis/Yellow Jaundice	<input type="checkbox"/>
Abnormal Heart Beats	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Gallstones or Gallbladder Trouble	<input type="checkbox"/>
Abnormal EKG	<input type="checkbox"/>	Cirrhosis of the Liver	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Alcoholism or Drug Dependency	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	Esophageal Varices	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	Gastritis	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	Colitis	<input type="checkbox"/>
Asthma/Bronchitis	<input type="checkbox"/>	Psychiatric Treatment	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	Skin Disorders	<input type="checkbox"/>
Emphysema/ COPD	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Respiratory Disease	<input type="checkbox"/>	Head/Neck Injury	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Back Injury Pain	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	Airway Obstruction (Nasal)	<input type="checkbox"/>
Major Allergies	<input type="checkbox"/>	Breast Cysts, Tumors or Abscesses	<input type="checkbox"/>
Palsy or Paralysis	<input type="checkbox"/>	Nipple Discharge (Except Normal Lactation)	<input type="checkbox"/>
Nervous/Muscle Disorder	<input type="checkbox"/>	Herpes or Cold Sores	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>
Self-Destructive Tendencies	<input type="checkbox"/>	Seizures or Epilepsy or Fainting Spells	<input type="checkbox"/>
Psychiatric Hospitalization or Care	<input type="checkbox"/>	Blackouts	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	Dentures, bridges, capped teeth or crowns	<input type="checkbox"/>
Kidney or Renal Disease	<input type="checkbox"/>	Loose teeth	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	Cosmetic bonding to teeth	<input type="checkbox"/>
Piercing other than ears	<input type="checkbox"/>	Any family members with bleeding problems	<input type="checkbox"/>
Positive blood test (see below)	<input type="checkbox"/>	Any family members with anesthesia problems	<input type="checkbox"/>
For HIV, AIDS, Hepatitis	<input type="checkbox"/>	Family history of cancer, heart trouble, stroke	<input type="checkbox"/>

**SURGICAL OPERATIONS** (Please include all surgeries, including cosmetic procedures and when/why/where):

Please list all present medications, including birth control pills, hormones, vitamins, herbal medications, diuretics, weight loss drugs. Please include over-the-counter medications as well.

**IMPORTANT:** Do you have allergic reactions to any medication/latex? ☐ Yes ☐ No If so, which medication(s)?

Have you, or any member of your family ever had any difficulties with any medications, drugs, or gases used for anesthesia?

☐ Yes ☐ No If yes, when and where? \_\_\_\_\_

Have you ever been on cortisone or steroid treatment? ☐ Yes ☐ No If yes, when? \_\_\_\_\_

Do you drink alcohol regularly? ☐ Yes ☐ No If yes, how much daily? \_\_\_\_\_ How much weekly? \_\_\_\_\_

Do you smoke? ☐ Yes ☐ No If yes, how much? \_\_\_\_\_ How long? \_\_\_\_\_

Are you pregnant? ☐ Yes ☐ No When was your last normal menstrual period? \_\_\_\_\_

How many pregnancies? \_\_\_\_\_ Number of births? \_\_\_\_\_ Breast Fed? ☐ No ☐ Yes If yes, for how long? \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_ By whom? \_\_\_\_\_

When was your last eye examination? \_\_\_\_\_ By whom? \_\_\_\_\_

When and where was your last: Chest X-Ray? \_\_\_\_\_ EKG? \_\_\_\_\_

Have you ever been under psychiatric care? ☐ Yes ☐ No When? \_\_\_\_\_ Please explain? \_\_\_\_\_

Have you had any recent blood work done? ☐ Yes ☐ No Where? \_\_\_\_\_

**INSURANCE INFORMATION - We accept most PPO plans (Insurance is ONLY applicable for medically necessary procedures)**

Insurance Company \_\_\_\_\_ Insurance ID# \_\_\_\_\_ Group# \_\_\_\_\_

Insured Name (If not under the patient's name): \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Tel#: ( ) \_\_\_\_\_ Social Security #: \_\_\_\_\_

\*Medicare#: \_\_\_\_\_ Is Medicare your Primary Insurance? Yes / No

**Assignment of Insurance Patients**

**I hereby authorize direct payment of surgical/medical benefits to Dr. Kevin Sadati for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.**

**Patient/Guardian Initials:** \_\_\_\_\_

**Medicare – Medicaid**

**I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I allow request of payment for authorized benefits to be made on my behalf.**

**Patient/Guardian Initials:** \_\_\_\_\_

**Assignment and Release**

**Should the account become delinquent, the entire amount shall be due and payable on demand. Any court charges, attorney fees, or other fees necessary to collect are payable by me. For any balances over 45 business days outstanding, I understand there may be a monthly fee for billing service(s). I understand I am responsible for payment in full at the time the service is rendered. A photocopy of this authorization is as valid and effective as the original.**

Patient Signature: (Guardian or Parent if Patient is a minor): \_\_\_\_\_ Date: \_\_\_\_\_

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT'S FINANCIAL RESPONSIBILITY FOR SURGERY

Health insurance plans exclude coverage for procedures seen as cosmetic or those deemed not medically necessary. (For example, insurance does not cover face lifts or cosmetic rhinoplasty)

It is important to understand that there are several costs that can be involved in surgery. For example, surgeon fees, anesthesia fees, laboratory tests, CT scans, injections, pre and post operative charges, complications and possible outpatient facility and/or hospital charges.

**It is important that you fully understand your individual health insurance plan - it is your responsibility. Please make sure to review your individual plan and/or call your insurance company for clarification.**

### Key Insurance Terms:

1. **Co-payments** – Fixed dollar amount you pay for a specific service, usually due on the day of service.
2. **Deductible** – A set amount you have to pay every year towards your health care services before your insurance company starts paying anything.
3. **Coinsurance** – The percentage of your medical bill you share with your insurance company after you've paid your deductible in full.
4. **Out-of-Pocket** – Refers to the amount of money you are required to pay for health care services. Some plans have out-of-pocket maximums, which after being fully met, the insurance company pays 100% of the member's health care costs. (Examples of out-of-pocket costs are **deductible** and **coinsurance**.)
5. **Less Obvious Health Insurance Costs** - In any type of insurance plan, there are some expenses that may be partially covered, or not covered at all. You should be aware of these expenses which contribute to your total healthcare costs. (Example: Some insurance plans only cover a certain number of office visits per benefit period.)

### \*Cancellation Policy:

We understand a situation may arise that could force you to postpone, or even cancel, your surgery. Please understand that such changes affect your surgeon, the surgery center staff and other patients. Dr. Kevin Sadati's time, as well as that of his staff, is a precious commodity and we request your courtesy when making changes.

#### **Please be sure to review the following cancellation policy:**

\*If you cancel 3 weeks prior to the date of your surgery, you will receive a full refund *less* \$500.00. \*If you cancel 2 weeks prior to the date of your surgery, 50% of Dr. Sadati's surgeon fee will *not* be refunded.

**Refunds will be processed within 60 days of the cancellation notice.**

**In signing this consent, you acknowledge that you have been informed about, and accept, responsibility for all financial costs involved with your procedure. It is important that you read the above information carefully and have had all your questions answered before signing this consent. Please keep in mind that we need as much notice as you can provide. Thank you.**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Financial Guarantor for Minor:** \_\_\_\_\_ **Witness:** \_\_\_\_\_