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

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: _____