



DR. JOHN DIAZ

Demographic Information

Full Name: _____ Today's Date: _____

Birth Date: _____ Age: _____ Sex: M F Married / Single / Divorced

Reason for consultation: _____

How did you hear about Dr. Diaz?: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Best Phone Number to Reach You: (check type) Mobile Home Work _____

Other Number: (check type) Mobile Home Work _____

E-mail: _____

Occupation: _____ Employer: _____

Social Security Number: _____ Drivers License Number: _____

Health Insurance Provider: _____ ID Number: _____

Name of Primary MD: _____ Telephone Number: _____

In Case of Emergency, Who Should We Contact: _____

Relationship: _____ What is their telephone?: _____

If you decide to have surgery will you be using financing?: _____

Other than the services we have already provided for you, what additional services would you like to learn about?

Juvaderm/Collagen

Botox

Latisse/Eyelash enhancement



DR. JOHN DIAZ

Medical History

Do you have or have you ever had any of the following?

Rheumatic Fever	Yes	No	Cancer	Yes	No
Heart Trouble	Yes	No	Kidney Problems	Yes	No
Heart Murmurs	Yes	No	Eye Diseases	Yes	No
Heart Palpitations	Yes	No	Hepatitis	Yes	No
Irregular Heart Beat	Yes	No	Thyroid Problem	Yes	No
Chest Pains	Yes	No	Asthma	Yes	No
Shortness of Breath	Yes	No	Anemia	Yes	No
Swelling of Ankles	Yes	No	Blood Disorders	Yes	No
High Blood Pressure	Yes	No	Skin Disorders	Yes	No
Herpes "Fever Blisters"	Yes	No	Trouble with dryness, soreness, burning, itching, or excessive tearing of eyes	Yes	No
Chronic Lung Problems	Yes	No	Any other serious illness?	Yes	No
Diabetes	Yes	No			

Please explain:

Bleeding/Scarring/Anesthesia:

Do you or any member of your family have difficulty with prolonged bleeding when cut? **Yes** **No**

Do you or a member of your family bruise easily? **Yes** **No**

Do you have a problem with excessive scarring or
have you ever formed a keloid after being cut? **Yes** **No**



DR. JOHN DIAZ

Have you or any member of your family ever had a problem with anesthesia? **Yes No**

If you are considering breast surgery, have you had a mammogram? **Yes No**

When was your last mammogram? _____ What was the result? _____

Women: Number of pregnancies: _____ Number of births: _____

Medications: Are you now or have you ever taken any medications on a regular basis (aspirin, birth control pills, vitamins included)? Please list:

Allergies: Are you allergic to or have you ever had a reaction to any medication, drug or local anesthetic? Please list:

Hospitalizations or prior surgeries, please list with dates:

Do any diseases run in your family? Please list: _____

Are you under the care of psychiatrist, now or ever? **No Yes**

Do you smoke? **No Yes** If yes, how much? _____

Do you drink? **No Yes** If yes, how much? _____

Previous drug use? **No Yes**

Height: _____ Weight: _____



DR. JOHN DIAZ

Agreement to release medical information, receive care, and assign benefits:

I understand that my medical information is confidential and will only be shared (when necessary) with other medical personnel taking care of me or with my insurance company. I authorize release of that information under those circumstances, and for all physicians/healthcare providers past and present to discuss my medical history and release my medical records to Dr. Diaz, or the doctors at Sunset Cosmetic Surgery Center, if needed. I agree that I am placing myself under their care, possible surgery or other treatments. I agree to be examined by the doctors for this purpose. I understand that I am financially responsible for these services and that they may not be covered by health insurance. I agree that any payments from insurance companies for my care (if applicable) will be disbursed to Dr. Diaz. If these payments are mailed to me I agree that I will assign/endorse them over to the above and forward them to Dr. Diaz.

Print Name

Signature

Date

Informed Consent for Photographs and Computer Aided Alterations

I specifically authorize Dr. Diaz and/ or his associates to take photographs of me. I specifically authorize and grant permission to him to utilize these photographs for any instructional or professional purposes including, but not limited to, use within his medical practice, publications, presentations and for demonstration purposes for the benefit of his prospective patients. It is further understood that any drawings, or computer alterations of photographs, are only for the purpose of graphic display and as a graphic aid. Such drawings or computer alterations are not intended to represent a guarantee or representation of what post-operative results will be. I further grant permission for the use of any medical record, illustration, photograph and/or other imaging record created in my case, for use in examination, testing, credentialing, and/or certifying purposes by the American Board of Plastic Surgery, Inc.

Print Name

Signature

Date

Witness: _____



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Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health



DR. JOHN DIAZ

information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the practice manager at 436 N. Roxbury Dr. Suite 205 Beverly Hills, CA 90210.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the practice manager at 436 N. Roxbury Dr. Suite 205 Beverly Hills CA 90210. You must provide us with a reason for your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the practice manager at 436 N. Roxbury Dr. Suite 205 Beverly Hills CA 90210. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the practice manager at 436 N. Roxbury Dr. Suite 205 Beverly Hills, CA 90210.

I hereby acknowledge that I have been presented with a copy of Dr. John Diaz's Notice of Privacy Practices.

Signature _____

Date _____

Name of Patient