PATIENT INFORMATION

Date:_____

Name(last, first, MI):_____Sex: Male Female
Address:_____City:_____State_____Zip_____
Home Phone #: ( )_____Cell: ( )_____Work #: ( )_____
Date of Birth: _____ Age: _____ SS# _____Email: _____

What would you like us to call you? Do you have a nickname? _____
Where may we call you? HOME WORK CELL ANY
May we leave a message with a family member on a machine? YES NO
May we mail/email you information on services our office or our affiliates offer? YES NO
What would you like to achieve with Plastic Surgery?_____
What Procedure are you interested in? _____
What time frame are you considering? 1-3 months 6-12 months Just need information
Are you interested in financing? YES NO
Who may we thank for referring you? _____

MARITAL STATUS (please circle): SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SPOUSE (or parent if minor):
Name:_____SS#:_____Date of Birth_____
Home Phone#: ( )_____ Work #: ( ) _____

YOUR EMPLOYMENT INFORMATION:
Occupation:_____ Employer:_____
Address:_____ Phone #: ( )_____

RESPONSIBLE PARTY'S NAME: _____ Phone # ( ) _____

PRIMARY INSURANCE:
Insurance Carrier: _____ Subscriber Name:_____
Address: _____Policy I.D.#:_____
City, State & Zip:_____ Group # _____
Phone #: ( ) _____

EMERGENCY INFORMATION:

Name: _____Relationship:_____
Address:_____City & State: _____
Zip: _____ Phone #: ( )_____

I hereby irrevocably assign and transfer all payment of benefits for the services rendered by Mark Mofid, M.D. to be made directly to him regardless of my insurance benefits, if any, and agree to allow a photocopy of my signature to be used to file insurance. I understand that each patient (or responsible party) is financially responsible for services rendered. In the instance of dispute with my insurance company regarding payment, I authorize Mark Mofid, MD to act on my behalf. While the business office is pleased to assist in the preparation and submission of insurance forms, the obligation for payment remains that of the responsible party. In the case of an accepted Worker's Compensation injury, it is understood that the patient is not financially responsible. I also authorize Mark Mofid, MD to render medical treatment.

_____ _____
Patient Signature Responsible Party's Signature

_____ _____
Date Date

MEDICAL INFORMATION:

Are you in good health at the present time? YES NO

If answer no, please explain. _____

Are you presently or have you recently been under the care of any other physician? _____

Please list who your Primary care Physician or your family doctor is. Please list their address & telephone number:

_____

_____

Have you been under the care of any physician for any medical or surgical condition in the last 5 years? If so, please list physician and condition treated for: _____

_____

Please list all surgery, including cosmetic surgery that you have had including the dates:_____

_____

Please list medications that you are currently taking. Including aspirin or ibuprofen. Please include dosages, frequency and the reason for taking the medication:_____

_____

_____

Do you have any known allergies: If so , please list:_____

Are you presently under psychological or psychiatric care? If so, please state therapist's name and length of treatment:

_____

Do you smoke? If so, how many packs per day? _____ Or per week _____
Do you drink alcohol? If so how many glasses a day? _____ Or per week _____
For Women: Is there a possibility that you are pregnant? YES NO
When was your last general exam? _____

Do you suffer from any of the following:
Asthma, Chronic Bronchitis, or other lung problems? YES NO
Heart Disease, including Angina, Arrhythmia's. or prior heart attacks? YES NO
Diabetes? YES NO
Kidney Disease? YES NO
Hepatitis, or other liver disease? YES NO
Peptic Ulcers? YES NO
Ulcerative Colitis or other intestinal problems? YES NO
Lupus, Seleroderma, or other autoimmune diseases? YES NO
Bleeding disorder or prolonged with surgery/dental work? YES NO
HIV or other communicative diseases? YES NO
Anxiety/Psychological disorder? YES NO
Other significant medical problems? _____

_____

HIPAA NOTICE OF PRIVACY PRACTICES DRS. MARK & MONA MOFID, M.D.,APC & DEL MAR LASER

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bill, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcements: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with request to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date:_____