THE NADERI CENTER FOR COSMETIC SURGERY SPECIALISTS

297 Herndon Pkwy, Suite 101, Herndon, VA 20170 Ph: 703.481.0002
5454 Wisconsin Ave, Suite 1655, Chevy Chase, MD 20815 Ph: 301.222.2020

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street & Apt #) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes **E-mail** _____

Contact Restrictions: _____ Drivers License # (include State) _____

❒ Female ❒ Male

Age _____ Birthdate ___/___/_____ SS# ___-___-_____ Sex ❒Transgender

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____ (Street & Suite #) _____ (City) _____ (State) _____ (Zip)

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____ (Street & Apt #) _____ (City) _____ (State) _____ (Zip)

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

I understand purely cosmetic consultations are $100 (effective 7/1/2011) payable in advance by credit card at the time of scheduling. This fee is non-refundable if I do not reschedule or cancel my appointment with at least 24 hours notice prior to my appointment time. Functional consultation fees will be billed to me &/or my insurance company. I understand that office visit charges are payable in full on the same day service is rendered. All payments for surgery are due at least 2 weeks in advance of surgery. If insurance can pay for part of my desired surgery then my insurance may be charged for the office visit(s). I understand that my contract is between The Naderi Center and myself and it is my responsibility to follow through with my insurance. I authorize The Naderi Center to bill my insurance company when appropriate. Regardless of insurance coverage, **I am responsible for all bills being paid in full in a timely manner**. I understand that should my account be placed with an agency or attorney for collection, then I agree to be responsible for all costs incurred in the collection of my account, including attorney's fees, interest at 1.5% per month (18% per annum), and all court costs. I understand I will not dispute any charges on my credit card for services or product rendered at The Naderi Center. If a dispute arises, I waive my HIPPA rights. I also understand, I am free to review my doctor online but if I choose to share my experience on the web then out of fairness I voluntarily waive my HIPAA privacy rights in order for my doctor to be able to post replies &/or photos in the discussion

Signature _____ **Date** _____

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Health History Form

Patient Name:
What Procedure(s) are you considering?

*DO YOU **NOW** OR HAVE YOU **EVER** HAD (You must circle an answer for each individual item):*

Heart Trouble	Yes	No	Any Hospitalization or Previous Surgery	Yes	No
Stroke	Yes	No	Any Eye Problems	Yes	No
Blood Pressure Abnormalities	Yes	No	Hepatitis or Cirrhosis of the Liver	Yes	No
Abnormal EKG	Yes	No	Easy scarring	Yes	No
Rheumatic Fever	Yes	No	Alcoholism or Drug Dependency	Yes	No
Shortness of Breath	Yes	No	Ulcers or G.I Problems	Yes	No
Chest Pain	Yes	No	Constipation	Yes	No
Asthma or Lung Disease	Yes	No	Vomiting Blood	Yes	No
Tuberculosis	Yes	No	Hemorrhoids	Yes	No
Coughing or Spitting Blood	Yes	No	Goiter or Thyroid Disorders	Yes	No
Hay Fever or Major Allergies	Yes	No	Diabetes	Yes	No
History of Anesthesia problems	Yes	No	Skin Disorders or rashes	Yes	No
Numbness or Paralysis	Yes	No	Arthritis	Yes	No
Anxiety or Nervous Breakdown	Yes	No	Fracture of Neck or Spine	Yes	No
Neurologic Disorder	Yes	No	Bleeding Tendency or Disorder	Yes	No
Insomnia	Yes	No	Abnormal Bleeding after Tooth Extraction	Yes	No
Recreational Drug Use	Yes	No	Airway Obstruction (Nasal)	Yes	No
Self-Destructive Tendencies	Yes	No	Previous Blood Transfusion	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Seizures or convulsions or fainting spells	Yes	No
Kidney Disease	Yes	No	Black outs	Yes	No
Missed or irregular last menstrual period	Yes	No	Dentures, bridges, capped teeth or crowns	Yes	No
Positive testing for: HIV, AIDS, Hepatitis	Yes	No	Loose teeth	Yes	No
Depression	Yes	No	Previous Cosmetic Dental Work	Yes	No
Family history of cancer, heart problems, stroke	Yes	No	Family history of with bleeding problems	Yes	No
Easy Bruising or bleeding	Yes	No	Family history of anesthesia problems	Yes	No
Any drug or medication ALLERGIES?	**YES**	**NO**	Pregnant or Breast Feeding	Yes	No

If you answered "yes" to any of the above, please explain fully below:

_____

_____

If you are considering breast or body surgery please specify **HEIGHT** _____ **WEIGHT**_____lbs.

1. **Please list all present medications**, including **Accutane**, **birth control pills**, hormones, and vitamins, **herbal** supplements, diuretics, **weight loss drugs, energy drinks**. Also, **topical** skincare medications or creams including tretinoin (Retin-A), Differin, Metro-gel, etc. **Include over-the-counter medications.**

_____

_____

1. Have you ever had an adverse reaction(s) to any skin related procedures or cosmetics? ❒ Yes ❒ No
Name of product/procedure and reaction:

_____

2. Do you have a history of cold sores or fever blisters? ❒ Yes ❒ No Date of last outbreak?_____

3. What is your ethnic background (for purposes of aesthetic treatments)?_____

4. In response to sun exposure, do you typically tan or burn? _____
Would you consider yourself to have a tan at this point in time? ❒ Yes ❒ No

5. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer and wine? ❒ Yes ❒ No If so, how much? _____

6. Do you smoke or use any **Nicotine** containing products (i.e. gum, patch, etc)? ❒ Yes ❒ No
If so, how much? _____ For how long? _____

7. Are you pregnant, breast feeding or actively trying to become pregnant currently or in near future?
❒ Yes ❒ No When was you last normal menstrual period? _____

IF YOU ARE TO BECOME PREGNANT, LET OUR OFFICE KNOW IMMEDIATELY. SOME PROCEDURES OR PRODUCTS ARE CONTRAINDICATED WITH PREGNANCY OR BREAST FEEDING AND MAY BE HARMFUL TO YOUR CHILD!

8. Primary Care Physician_____ Phone Number _____

9. Have you ever been under psychiatric care? ❒ Yes ❒ No Please explain when and for what condition?

_____

_____

10. Please list all hospitalizations, surgeries and procedures , including cosmetic: (include where, when and why for each): _____

_____

_____

11. What are your expectations for your appointments?

_____

12. Do you understand that there is no such thing as "perfection" and that the goal of any cosmetic procedures is "improvement?" ❒ Yes ❒ No

13. Do you understand that there are risks associated with all procedures such as infection, allergic reaction, scarring, asymmetry, need for further procedures, etc? ❒ Yes ❒ No

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

Signature: _____ Date: _____
(If under 18 then signature and name of parent or guardian)

Print Name**:**_____

THE NADERI CENTER CANCELLATION / RESCHEDULING POLICY

At The Naderi Center, we are dedicated to setting aside appropriate time to meet all of your needs and answer all of your questions. We ask in return that you provide the office with at least 24 hours courtesy notice in the case that you need to cancel or reschedule your appointment.

Our cosmetic consult fee varies by consultation type. The consultation fee is payable in advance by credit card at the time of your scheduling. This fee will be non-refundable if you reschedule or cancel your appointment with less than 24 hour notice. We thank you for your understanding.

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

SIGNATURE:_____

Print Name:_____

PHOTOGRAPH / VIDEO AUTHORIZATION AND RELEASE

I, _____, authorize The Naderi Center for Cosmetic Surgery & Skin Care, PLLC, Shervin Naderi, MD, FACS, Jessica Kulak, MD, or Erica Anderson and/or their staff or representative(s), to take photographs, slides or videotapes of me or parts of my face and body for medical purposes to be used for my care, medical presentations or publications, marketing, literature, case presentation, websites or print. These photographs & videos will not be sold by The Naderi Center or used for other purposes by The Naderi Center. I authorize the use of these images and videos, without compensation to me. I understand that photography / videography is an integral part of cosmetic surgery practices.

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Naderi, Dr Kulak, Dr Anderson and/or The Naderi Center for Cosmetic Surgery & Skin Care, PLLC in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, YouTube, and social media sites for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Naderi, Dr Kulak, or Dr. Anderson for which the doctors may receive direct or indirect remuneration.
1. **I will not be identified by name in any of the media described above**; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features or descriptions that identify me.
2. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to The Naderi Center. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization. If I do not revoke this authorization, it shall not expire.
3. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Naderi, Dr Kulak, Dr Anderson and/or The Naderi Center for Cosmetic Surgery & Skin Care, PLLC.
4. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.
5. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.
6. By consenting I agree to discuss any and all of my potential concerns with The Naderi Center and not discuss my experience on the internet.

I consent to use of my photos / videos with for marketing and educational purposes.

I release and discharge Dr. Naderi, Dr Kulak, Dr Anderson and/or The Naderi Center for Cosmetic Surgery & Skin Care, PLLC from all liability that in any way arises out of:

- any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and
- any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and marketing and I certify that I have read this Authorization and Release carefully and fully understand its terms.
If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact **The Naderi Center** at (703) 481-0002 or 301-222-2020. If under 18, guardian or parent must sign.

Print Name _____ Date _____

Signature _____ Witness _____