THE NADERI CENTER
PLASTIC SURGERY & DERMATOLOGY

NEW PATIENT PACKET

Patient Information

Name: _____
Last First Middle

Age: _____ Date of Birth: _____

Gender: ☐ Female ☐ Male ☐ Female to Male Transgender ☐ Male to Female Transgender

Address: _____

Cell Phone: _____ Other Phone: _____

Email: _____

Employer Information

Employer: _____ Occupation: _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Primary Care Physician

Name of Practice: _____ Doctors Name: _____

Phone: _____

Address: _____

Primary Insurance: _____ Secondary Insurance: _____

Pharmacy Information

Preferred Pharmacy: _____ Phone: _____

Address: _____

HEALTH HISTORY FORM: **DO YOU HAVE OR HAVE YOU EVER HAD:**

Y	N	CARDIOVASCULAR
☐	☐	Heart Attack or Heart trouble
☐	☐	Chest Pain
☐	☐	Stroke
☐	☐	Palpitations/Irregular Heart Rhythm
☐	☐	Heart Surgery / Pacemaker / Stents
☐	☐	Easy Fainting / Black-out spells
☐	☐	Heart Murmur or Heart Valve Problems
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure

Y	N	LUNG
☐	☐	Asthma
☐	☐	Emphysema/COPD
☐	☐	Shortness of Breath
☐	☐	Chronic Cough
☐	☐	CPAP use
☐	☐	Sleep Apnea

Y	N	HEMATOLOGY
☐	☐	Easy Bruising
☐	☐	Anemia
☐	☐	History of Blood Transfusion
☐	☐	History of Blood Clot (DVT or Pulmonary Embolus)
☐	☐	Bleeding Disorder

Y	N	NEUROLOGIC
☐	☐	Seizures/Epilepsy
☐	☐	Fainting Spells
☐	☐	Dizziness
☐	☐	Frequent or Severe Headaches
☐	☐	Facial Paralysis or Numbness

Y	N	PSYCHOLOGICAL
☐	☐	Self-destructive Tendencies
☐	☐	Anxiety or Nervous Breakdowns
☐	☐	Depression or Bipolar
☐	☐	Schizophrenia
☐	☐	Body Dysmorphic Disorder

Y	N	WOMAN
☐	☐	Pregnant
☐	☐	Breastfeeding
☐	☐	Actively trying to get pregnant (includes IVF treatment)

Y	N	NOSE
☐	☐	Breathing Problems
☐	☐	History of Nasal Trauma
☐	☐	History of Nose Bleeds
☐	☐	Previous Nasal Surgery (Any form of nose surgery)
☐	☐	Sinus Problems

Y	N	EYES
☐	☐	Eye Dryness
☐	☐	Excessive Eye Tearing
☐	☐	Previous Eye Surgery
☐	☐	Glaucoma

Y	N	SKIN
☐	☐	History of Cold Sores
☐	☐	Acne
☐	☐	Rosacea
☐	☐	Melasma or PIH (Post Inflammatory Hyperpigmentation)
☐	☐	Skin Cancer or Precancerous Lesions
☐	☐	Poor Wound Healing or Excessive Scarring
☐	☐	Easily Sun Burn

Y	N	OTHER
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	HIV or AIDS
☐	☐	Hepatitis B or C
☐	☐	Stomach Ulcers or Colitis
☐	☐	Radiation Treatment for Cancer
☐	☐	Recreational Drug Use (Marijuana, Cocaine, etc.)
☐	☐	Disease or Medication Causing Immune System Suppression
☐	☐	Implants (Heart Valve, Pacemaker, Hip, Knee)
☐	☐	Diabetes
☐	☐	Thyroid Disease or Goiter
☐	☐	General Anesthesia Problems for you or family members

Y	N	SOCIAL
☐	☐	Do you smoke or use any Nicotine containing products? (i.e. vaping, hookah, Juul, gum, patch, etc.) **If YES describe type and how often:** _____
☐	☐	Do you drink alcohol? **If YES how many drinks per week:**_____

Please elaborate on any items circled YES as well as any other medical conditions or any other medical history:

_____

_____

_____

If you are considering breast or body surgery, please specify:					
HEIGHT:		**WEIGHT:**			
PANT SIZE:		**DRESS SIZE:**		**BRA SIZE:**	

Y	N	Are you allergic to or have you had an adverse reaction to the following:
☐	☐	Local anesthesia (Novacaine, Lidocaine, etc)
☐	☐	Sedatives (Xanax, Valium,etc)
☐	☐	Codeine or Other Pain Killers
☐	☐	Sulfa Containing Medications
☐	☐	NSAIDS (Ibuprofen, Aspirin, Celebrex, etc)
☐	☐	Tape or Adhesives
☐	☐	Antibiotics
☐	☐	Latex

Please list all Medication Allergies:

Y	N	Are you currently using or within the last 12 months used any of the following medications?
☐	☐	Accutane
☐	☐	Weight loss drugs or appetite suppressants
☐	☐	Blood Thinners (Coumadin, Plavix, Aspirin)
☐	☐	Steroids (Cortisone, Prednisone, etc)
☐	☐	Vitamins (Vitamin D, E, DHA, Omega 3 or 6)
☐	☐	Supplements (Ginkgo, Ginseng, St. John's Wort, etc)

List Medications, Vitamins, Supplements and Skincare Products:	
MEDICATION NAME	**DOSE**

Please list all prior surgeries (Medical and Cosmetic):	
DATE:	**PROCEDURE:**

Have you had any Psychiatric Care or Psychiatric Hospitalization? If so, please explain when and condition treated:

BY TYPING YOUR NAME IN THE "Patient Signature" SPACE, you certify that all the information contained above is true and accurate to the best of your knowledge. You understand that it is **your responsibility** to notify our at The Naderi Center if you are currently **pregnant** or actively trying to become pregnant or are **breast feeding**, as some procedures or products are contraindicated with pregnancy or breastfeeding and may be harmful to your child. It is your responsibility to tell us about all your medications, supplements, and nicotine use as they may adversely affect surgical or treatment outcome. **You understand that it is your responsibility to update us at each visit from now on if there are any changes to this information**. You also understand that the goal of any cosmetic procedure is improvement, and there is no such thing as perfection, and that there is no such thing as perfect symmetry.

Patient (or legal guardian) Signature Date

THE NADERI CENTER PRACTICE POLICIES

Cancellation / Rescheduling Policy

We understand that unexpected emergencies do arise but we ask that you kindly provide our office with at least 24 hours courtesy notice in the case that you need to cancel or reschedule your appointment. If you reschedule or cancel your appointment with less than 24-hour notice, a "no-show fee" equal to the new-patient consultation fee would be collected at the time of scheduling another appointment. Consultation fees vary by appointment type and doctor and range from $100-$400.

Patient (or legal guardian) **Initial:** ☐

HIPAA Notice of Privacy Practices

By signing this form, you acknowledge that you have had the opportunity to review a copy of The Naderi Center's Notice of Privacy Practices. By signing this form, you understand the contents of the Notice and how it applies to you, and you understand how your information may be used, and acknowledge that all of your questions regarding the contents of the Notice have been answered. If you have questions about the use or disclosure of your information, you can contact:
The Naderi Center management at (703) 481-0002 or 301-222-2020 or by email, Manager@nadericenter.com

Patient (or legal guardian) **Initial:** ☐

Financial Responsibility Policy

By signing this form, you understand that office visit charges are payable in full on the same day service is rendered. All payments for surgery or certain other types of office procedures are due at least 3 weeks in advance prior to the date of surgery or the procedure. You authorize The Naderi Center to bill your insurance company when appropriate. Regardless of insurance coverage or benefits, you understand that **you are responsible for all bills being paid in full in a timely manner**. You agree that due to the nature of the purchases, you will not dispute any charges on your credit card for services rendered or products purchased at/from The Naderi Center because the service rendered or product cannot be returned to The Naderi Center for a refund. If a dispute arises, you agree to temporarily waive your HIPPA rights so that The Naderi Center can discuss the details of the purchase and the case with the appropriate financial parties involved.

Patient (or legal guardian) **Initial:** ☐

BY TYPING YOUR NAME IN THE "Patient Signature" SPACE, you agree to have read the above policies and agree to all terms with no exceptions:

Patient (or legal guardian) Signature Date

PHOTOGRAPH / VIDEO AUTHORIZATION AND RELEASE

I, _____, authorize The Naderi Center for Cosmetic Surgery & Skin Care, PLLC, Shervin Naderi MD FACS, Jessica Kulak MD, Alexandra Snodgrass MD, Erica Anderson MD and/or their staff or representative(s), to take photographs, slides or videos of me or parts of my face and body for medical purposes to be used for my care, medical presentations, publications, marketing, literature, case presentation, websites, social media, and print. These photographs & videos will not be sold 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 and even if I do not give consent herein for display of my photos or videos online or in print, confidential photographs will be taken for my routine care and follow-up as part of my medical records and progress.

I understand that:

1. Such photographs, slides or videos may be published by Dr. Naderi, Dr. Kulak, Dr. Anderson, Dr. Snodgrass and/or The Naderi Center for Cosmetic Surgery & Skin Care, PLLC and its staff 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 and results. I understand that such uses may also include marketing on behalf of Dr. Naderi, Dr. Kulak, Dr. Snodgrass or Dr. Anderson and The Naderi Center staff for which the doctors may receive direct or indirect remuneration.
2. **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 my face, features or descriptions that identify me.
3. 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.
4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Naderi, Dr. Kulak, Dr. Anderson, Dr. Snodgrass and/or The Naderi Center for Cosmetic Surgery & Skin Care, PLLC. However as stated above, confidential photographs will be taken prior to my treatment.
5. 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.
6. A copy of this Authorization is valid as the original. I have the right to ask and 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.
7. By consenting I also agree to discuss any and all of my potential results and outcome concerns with The Naderi Center staff and management and not discuss my experience on the internet.

I release and discharge Dr. Naderi, Dr. Kulak, Dr. Anderson, Dr. Snodgrass, their staff and The Naderi Center for Cosmetic Surgery & Skin Care, PLLC from all liability that in any way arises out of display of my photos and videos in addition to:

- any and all rights that I may have or may have had in the photographs, slides or videos 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 videos 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 videos, I can contact **The Naderi Center management** at (703) 481-0002 or 301-222-2020 or by email, Manager@nadericenter.com.

BY TYPING YOUR NAME IN THE "Patient Signature" SPACE, you agree to have read the above policies and agree to all terms with no exceptions:

Patient (or legal guardian) Signature Date