PATIENT INFORMATION

Name_____ Age_____ Sex_____ Date _____

S.S.#_____ Driver's Lic# _____ Birthdate _____

Single _____ Married _____ Widowed _____ Divorced _____

Address _____

City_____ State _____ Zip code _____

Cell Number ( ) _____Work Number ( ) _____Home Number ( ) _____

Occupation _____ Employer: _____

Who is the responsible party: _____ E-Mail:_____

Person to contact in case of emergency: _____ Phone number ( ) _____

Purpose of Consultation:_____

Referred by: _____

I. MEDICAL QUESTIONNAIRE: *(PLEASE MARK ONLY IF IT APPLIES TO YOU)*

Have you ever had any heart problems?	High blood pressure	___
	Low blood pressure	___
	Heart attack	___
	Heart murmur	___
	Chest pain/tightness	___
	Irregular heart beat	___
	Shortness of breath	___
Have you ever had any lung problems?	Bronchitis/Pneumonia	___
	Asthma	___
	Shortness of breath	___
	Tuberculosis	___
Have you ever had any eye, ear, nose or throat problems?	Dry eyes	___
	Blurred vision	___
	Glaucoma	___
	Corrective lenses	___
	Ear disease	___
	Nosebleeds	___
	Difficulty breathing	___
	Nasal allergies	___
	Sinus disease	___
	Other	___
Have you ever had gastrointestinal problems?	Ulcers	___
	Gastrititis	___
	Colitis	___
	Diverticulitis	___
Have you ever had any musculoskeletal/ neurological problems?	Convulsion	___
	Epilepsy	___
	Headaches	___
	Arthritis	___
	Other	___
Have you ever had any hematological/metabolic problems?	Anemia	___
	Bleeding problems	___
	Blood transfusion	___
	AIDS virus exposure	___
	Autoimmune disease	___
	Diabetes	___
	Thyroid disease	___
	Hepatitis	___
Have you ever been treated for psychiatric/ emotional problems?	Depression	___
	Anxiety	___
	Other	___

Do you have any medical problems that have not been covered? _____(Explain below)
Do you smoke cigarettes? _____ How much? _____
Do you drink alcoholic beverages? _____ Socially Daily
Do you take any recreational drugs? _____
Patient height _____ Patient weight _____
Do you take any diet medication? _____

II. MEDICAL HISTORY

Patient Name: _____

Name & city of your personal physician _____
Are you presently under the care of a physician for any medical condition? _____
_____

A. SURGICAL HISTORY – Please list all previous surgeries (including cosmetic)

OPERATI ONS	**SURGEON NAME**	**YEARS OF OPERATIONS**
_____	_____	
_____	_____	
_____	_____	
_____	_____	

B. HOSPITIZATIONS (Other than for surgery)

ILLNESS	**PHYSICIAN/DATE**
_____	_____
_____	_____
_____	_____

III. MEDICATIONS & VITAMINS/DIET PILLS

Name of Drugs	Strength/Dosage	Condition Treated
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. ALLERGIES: (Please list any allergies to any medications, tapes, or antiseptic cleansers)

_____
_____

V. FAMILY HISTORY: (Please indicate with an "X" if any immediate family member has ever had any of the following?

Heart disease ___
Bleeding disorder ___
Diabetes ___
Autoimmune ___
Anesthetic complications ___
Other ___

Date: _____

_____
Patient Signature

_____
Clinic Staff Signature

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within the organization for the purpose of providing you with quality healthcare.

- Your confidential healthcare information may be released to your insurance provider for the purpose of the clinic receiving payment for providing you with needed healthcare services.

- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.

- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.

- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective or untoward event to a biological product (food or medicine).

- Your confidential healthcare information may <u>not</u> be released for any other purpose than that which is identified in this notice.

- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.

- You may be contacted by the clinic to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

- You have the right to restrict the use of your confidential healthcare information. However, the clinic may chose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

- You have the right to receive confidential communication about your health status.

- You have the right to review and photocopy any/all portions of your healthcare information.

PRIVACY NOTICE (continued)

- You have the right to make changes to your healthcare information.

- Your have the right to know who has accessed your confidential healthcare information and for what purpose.

- The clinic is required by law to protect the privacy of its patients. It will keep confidential any and all patients healthcare information and will provide patients with a list of duties or practices that protect confidential information.

- The clinic will abide by the terms of this notice. The clinic reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.

- You have the right to complain to the clinic if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the clinic:

A. JOHN VARTANIAN, M.D.
520 E. BROADWAY, SUITE 200
GLENDALE, CA 91205

- All complaints will be investigated. No personal issue will be raised for filing a complaint with the clinic.

- For further information about this Privacy Notice, please contact Kathrine at our office at (818) 662-0600.

- This notice is effective as of Date of Effectiveness. This date must not be earlier than the date on which the notice is printed or published.

I acknowledge that I have been given a copy of this Privacy Notice.

_____ _____

Signature of patient or authorized representative Date

A. John Vartanian, MD
520 E. Broadway Ave., Suite 200
Glendale, CA 91205
TEL (818) 662-0600 FAX (818) 662-0145

Record of Authorization for Taking and Publication of Photographic and Video Images

1. In connection with the medical services and consultation, which I am receiving from my physician, **A. John Vartanian, MD**, I consent that photographic and video images may be taken of me (or a minor I am consenting for). Dr. Vartanian may utilize these images for educational purposes, medical publications, or in other media. The identity (name) of the photographed will not be revealed to others in conjunction with any publication or use of these images.

2. The undersigned acknowledges that he/she relinquishes ownership and interest in these photographic/video images or any right to profit or gain through the use of these images. Ownership of these images is transferred to Dr. Vartanian.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____
(Parent / Guardian)

Relationship: _____

Physician Witness: _____

Optional Witness: _____