Christopher I. Zoumalan, M.D., Inc.
Aesthetic and Reconstructive Oculoplastic Surgery
9401 Wilshire Blvd. Suite 1105 Beverly Hills, CA. 90212

Patient Registration Information

Date: _____

Name_____
Last First Middle

Date of Birth_____ Age_____ Sex M F

Home Address: _____

City_____ State_____ Zip_____

Home Phone (_____)_____Work_(_____)_____

Cell Phone (_____)_____E-Mail_____

***How would you prefer we contact you regarding care at our center? (Please circle all that you are comfortable with):*

Email Cell Phone Work Home Home Phone

Would you allow us to include your email when we send out our newsletters? You can always remove yourself later ***Y or N***

Occupation_____Employers Name & Address_____

Marital Status ___Minor ____Single ____Married ___Widowed ____Divorced ____Separated

Name of Spouse (or parent if Minor)_____Phone_____

Emergency Contact_____Relationship:_____Phone_____

Family Doctor_____Phone_____

Ophthalmologist or Optometrist _____Phone_____

Pharmacy Phone_____
Company Number

How did you hear about us? Google_____ Yelp_____ Realself_____ Other_____

Insurance information

Primary Insurance_____

Secondary Insurance_____

Policy Holder's Name (if different from above) _____DOB_____

SSN#_____ Relationship to Patient_____

Authorization: I hereby authorize Dr. Christopher Zoumalan to be the attending physician and to administer to me any examination, treatment, and medications he deems therapeutic to my presenting complaint. I hereby authorize Dr. Christopher Zoumalan to furnish information to my insurance carriers concerning this illness and I hereby irrevocably assign to the doctor all payments for medical services.

Signature of Patient/Parent/Guardian: _____ Date:_____

Patient Name: _____ Date:_____

Have you ever suffered from?

	Yes	No
Heart disease	Y	N
High blood pressure	Y	N
Heart attack	Y	N
Pacemaker	Y	N
Emphysema	Y	N
Asthma	Y	N
Blood disease	Y	N
Kidney Disease	Y	N
Glaucoma	Y	N
Diabetes	Y	N
Jaundice/Hepatitis	Y	N
Cancer	Y	N
Anemia	Y	N
High or Low Thyroid	Y	N
Easy bruising	Y	N
HIV	Y	N
Facial Trauma	Y	N

If yes, please explain:_____

_____

Dermatologic History

Skin Cancer	Y	N
Cold sores or Herpes	Y	N
Keloids	Y	N
Hypertrophic Scarring	Y	N
Skin Pigmentation	Y	N
Reaction to local anesthetic	Y	N

If yes, please explain:_____

_____

Do you take any of the following?

Blood press. Meds	Y	N
St. John's Wort	Y	N
Aspirin/Advil	Y	N
Coumadin/Plavix	Y	N
Fish Oil	Y	N
Vitamins C, E, K	Y	N
Ginseng/Garlic	Y	N
Biotin	Y	N

Do you take Herbal or Homeopathic meds?

What medications are you currently taking?

_____

_____

_____

When is your timeline for your surgery or procedure?

_____

_____

Please list your medical problems

_____

_____

Please list any surgeries you have had

_____

_____

Have you or a family member ever bleed abnormally from a prior surgical procedure? Y N
If yes: please explain _____

What medications are you allergic to? _____

Do you have any of the following habits?

Smoking	Y N	Frequency	Years
Alcohol	Y N	Frequency	Years
Recreational drugs	Y N	Frequency	Years

Female Patients:
Are you pregnant or breast feeding? Y N
Do you take Birth Control Pills? Y N

Do you have any allergies to eggs or albumin? Y N

If yes explain:_____

When was the last time you had a physical examination by your

doctor?_____

When was your last regular eye exam?_____

Do you have any eye problems (ie glaucoma, infections)? Y N
Have you had any prior eyelid surgeries (ie upper or lower blepharoplasty) or laser procedures (ie LASIK)? Y N

If yes explain:_____

Do you have a history of dry eyes? Y N

If yes explain:_____

Have you ever received Botox or Fillers (e.g. Fat Injections, Juvederm/Restylane/etc)?
What kind/When/Where?

Have you ever had any allergic reactions or complications from Botox or Fillers?
If yes, how:

Have you ever consulted a professional for emotional problems? Y N
If yes, who and when:

Do you have any loose or false teeth? Y N

What is your reason for today's visit:

_____

_____

Consent for photography

I authorize Dr. Zoumalan to photograph BEFORE/AFTER pictures. I agree that he may use the photographs for purposes deemed necessary for medical records.

Patient Initials Yes____ No____

I hereby grant permission for the use of any of my medical records including illustrations, photographs of other imaging records created in my case, videos, for use in the publication in medical journals or books, Dr. Zoumalan's website, presentations, social media and or anonymously.

Patient Initials Yes____ No____

I fully understand and acknowledge the purpose of the use of my pictures.

Patient/Parent/Guardian_____ Date_____

Witness: _____Date_____

Notice to Consumers

Medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

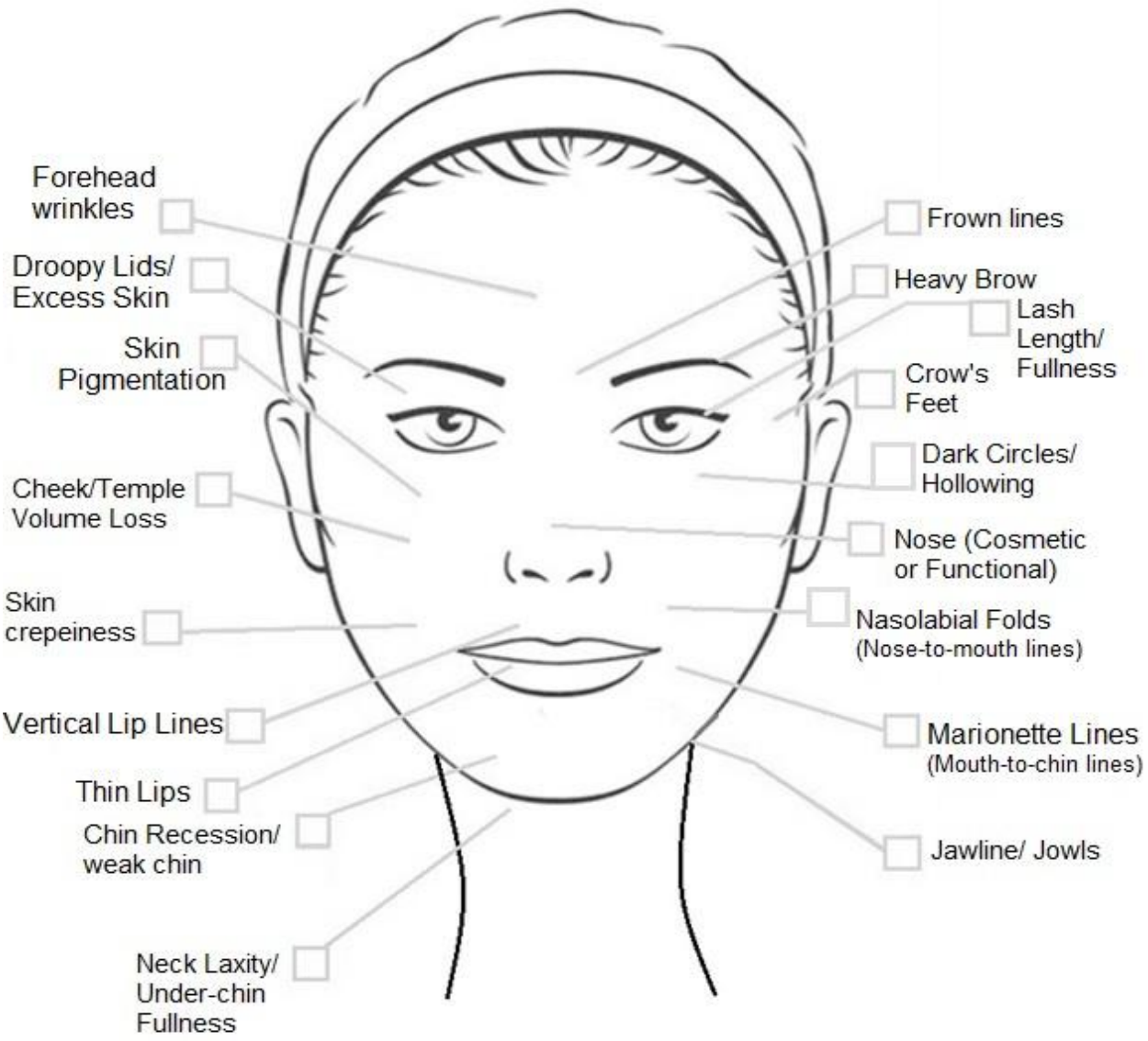
Patient Name: _____

Patient Signature: _____Date: _____

Christopher Zoumalan, M.D.
9401 Wilshire Boulevard Suite 1105| Beverly Hills, CA

Cosmetic Questionnaire

Please indicate any areas of interest
or concern by checking the respective check boxes below:



How would you like to improve your skin?_____

What skincare products do you use at home?_____

Do you use sunblock?_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to my privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I can request and review your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime at the address above to obtain the current coy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

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PLEASE READ CAREFULLY

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean_____(insert name of patient or guardian)

"Physician" shall be understood to mean Christopher I. Zoumalan, M.D. I understand that I am entering into a contractual relationship with the physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I, initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified and in good standing by the American Board of Medical Specialties in the same specialty as the Physician.

I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by the American Board of Medical Specialties in the same specialty as the Physician.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____ _____

Physician Signature Patient/Guardian Signature

_____

Effective from Date of Treatment: