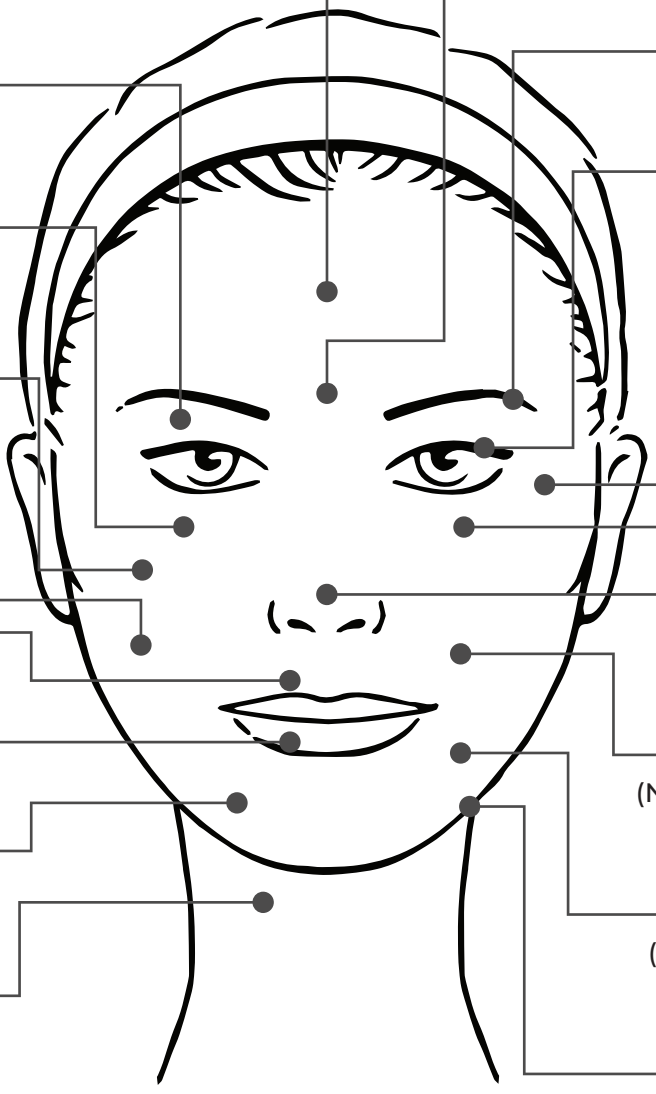
CHRISTOPHER ZOUMALAN, M.D.
9401 Wilshire Boulevard Suite 1105| Beverly Hills, CA

COSMETIC QUESTIONNAIRE

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



- ☐ Forehead Wrinkles
- ☐ Droopy Lids/ Excess Skin
- ☐ Skin Pigmentation
- ☐ Cheek/Temple Volume Loss
- ☐ Skin Crepeiness
- ☐ Vertical Lip Lines
- ☐ Thin Lips
- ☐ Chin Recession/ Weak Chin
- ☐ Neck Laxity/ Under-chin Fullness
- ☐ Frown Lines
- ☐ Heavy Brown
- ☐ Lash Length/ Fullness
- ☐ Crow 's Feet
- ☐ Dark Circles/ Hollowing
- ☐ Nose (Cosmetic or Functional)
- ☐ Nasolabial Folds/ (Nose-to-mouth Lines)
- ☐ Marionette Lines/ (Mouth-to-chin Lines)
- ☐ Jawline/Jowls

How would you like to improve your skin? _____

What skincare products do you use at home? _____

Do you use sunblock? _____

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: Employer's Name:

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: Phone:

How did you hear about us? (circle those that apply) ☐ Google ☐ Yelp ☐ Realself ☐ Instagram

Referred by (if applies):

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.

☐ **By checking this box and typing my name below, I am electronically signing this registration form.**

Last Name: First Name: Middle Initial: Date:

☐ **I have signed this application as an authorized guardian on behalf of the patient.**

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

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

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

Do you have a history of dry eyes? ☐ Y ☐ N

Have you ever received Botox or Fillers (e.g. Fat Injections, Juvederm / Restylane / etc)? ☐ Y ☐ N

Have you ever had any allergic reactions or complications from Botox or Fillers? ☐ Y ☐ N

Have you ever consulted a professional for emotional problems? ☐ Y ☐ N

Do you have any loose or false teeth? ☐ Y ☐ N

What is your reason for your visit:

Have you ever suffered from?

Heart disease	☐ Y	☐ N	Diabetes	☐ Y	☐ N
High blood pressure	☐ Y	☐ N	Jaundice / Hepatitis	☐ Y	☐ N
Heart attack	☐ Y	☐ N	Cancer	☐ Y	☐ N
Pacemaker	☐ Y	☐ N	Anemia	☐ Y	☐ N
Emphysema	☐ Y	☐ N	High or Low Thyroid	☐ Y	☐ N
Asthma	☐ Y	☐ N	Easy bruising	☐ Y	☐ N
Blood disease	☐ Y	☐ N	HIV	☐ Y	☐ N
Kidney Disease	☐ Y	☐ N	Facial Trauma	☐ Y	☐ N
Glaucoma	☐ Y	☐ N			

If yes, please explain: _____

Dermatologic History:

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

If yes, please explain: _____

Do you take any of the following?

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

Do you take Herbal or Homeopathic meds? ☐ Y ☐ N

What medications are you currently taking?

_____

When is your timeline for your surgery or procedure?

_____

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, presentations, social media, Dr. Zoumalan's website or any of his affiliated websites, and or anonymously.

Patient Initials _____ ☐ Yes ☐ No

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

☐ **By checking this box and typing my name below, I am electronically signing this consent.**

Last Name: _____ First Name: _____ Middle Initial: _____ Date: _____

☐ **I have signed this application as an authorized guardian on behalf of the patient.**

NOTICE TO CONSUMERS

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

(800) 633-2322

www.mbc.ca.gov

☐ **By checking this box and typing my name below, I am electronically signing this notice.**

Last Name: | First Name: | Middle Initial: | Date:

☐ **I have signed this application as an authorized guardian on behalf of the patient.**

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.

☐ **By checking this box and typing my name below, I am electronically signing this notice.**

Last Name: _____ First Name: _____ Middle Initial: _____ Date: _____

☐ **I have signed this application as an authorized guardian on behalf of the patient.**

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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.

☐ **By checking this box and typing my name below, I am electronically signing this form.**

Last Name: First Name: Middle Initial: Date:

☐ **I have signed this application as an authorized guardian on behalf of the patient.**

Physician Signature