FLORIDA
FACE AND BODY

PLEASE PRINT CLEARLY

Last Name _____First Name _____ MI _____

Local Address _____

City _____ State _____ Zip code_____

Home # _____ Cell#_____ Work # _____

Email _____

Date of Birth _____ Age _____ Sex ☐M ☐F

Primary Care Physician _____ Phone # _____

Are you a year round resident? ☐ Yes ☐ No

Northern Home Address _____

City _____ State _____Zip _____

Northern Home Phone # _____

Emergency Contact or Next of Kin

Name _____

Relationship _____

Home # _____ Cell#_____ Work # _____

Referral Information

Whom may we thank for referring you to our office?

_____

☐Friend/Patient ☐My Primary Care Physician ☐Website ☐Social Media Site
☐Billboard ☐Magazine Ad ☐Review Site ☐Our Eye Clinic ☐Flyer ☐Google

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PERSONAL MEDICAL HISTORY

Do you have any chronic medical problems? *[Fill in box for those that apply]*

Age: _____ Weight: _____ Height: _____ B/P: *[Avg. Resting B/P]* _____

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Seizures
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Asthma
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Psychiatric Diagnosis
- ☐ Bleeding Problems
- ☐ Liver Disease
- ☐ Gastric Reflux
- ☐ HIV or AIDS
- ☐ Stroke
- ☐ Hepatitis
- ☐ Emphysema
- ☐ Stomach Problems
- ☐ Other: _____
- ☐ Other: _____

Are there any issues with anesthesia? ☑ Yes I ☑ No

If yes, please explain? _____

Please list all prior Operations:	**Date**	**List any complications:**
1. _____	____/____/____	_____
2. _____	____/____/____	_____
3. _____	____/____/____	_____

Please list all prior Hospitalizations:	**Date**	**List any complications:**
1. _____	____/____/____	_____
2. _____	____/____/____	_____
3. _____	____/____/____	_____

Please list ALL CURRENT medications and/or dietary supplements including:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins, and Herbal Supplements)

Are you on blood thinners? o Yes I o No

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list ALL allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc.)

_____

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SOCIAL HISTORY

Have you ever smoked tobacco/Hookah/Vape products? ☐ Yes | ☐ No

If Yes, # of packs per day: _____ # of years: _____

If you quit, when? _____

Do you use Recreational Drugs? ☐ Yes | ☐ No

If Yes, list type: _____

Do you Exercise? ☐ Yes | ☐ No

If Yes, how often: _____ How long: _____

Type of Exercise? _____

Is your Level of Activity related to health limitations? ☐ Yes | ☐ No

If Yes, please explain: _____

HEART QUESTIONNARE

Have you had blood drawn in the past 3 months? ☐ Yes | ☐ No

If Yes, Location: _____

Have you had an EKG done in the last year? ☐ Yes | ☐ No

If Yes, Location: _____

Have you had a recent Physical Exam? ☐ Yes | ☐ No

If Yes, Doctor's Name: _____

Doctor's Phone Number: _____

FEMALE QUESTIONNARE

Are you currently pregnant? ☐ Yes | ☐ No

Have you had had any previous pregnancies? ☐ Yes | ☐ No

Total pregnancies: _____

☐ Natural Delivery ☐ C-Section Delivery

Do you plan on having any or any more children? ☐ Yes | ☐ No

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REVIEW OF SYSTEMS

Please answer the following ***Yes or No questions to the best of your ability***. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure	☐ Yes | ☐ No
Heart Attack	☐ Yes | ☐ No
Angina/chest pain	☐ Yes | ☐ No
Heart bypass surgery	☐ Yes | ☐ No
Pacemaker	☐ Yes | ☐ No
Heart Failure	☐ Yes | ☐ No
Irregular Heartbeat	☐ Yes | ☐ No
Heart Murmur	☐ Yes | ☐ No

RESPIRATORY

Abnormal Chest X-ray	☐ Yes | ☐ No
Asthma	☐ Yes | ☐ No
Bronchitis	☐ Yes | ☐ No
Emphysema	☐ Yes | ☐ No
Recent Chest Infection	☐ Yes | ☐ No
Shortness of Breath	☐ Yes | ☐ No
Shortness of Breath at night	☐ Yes | ☐ No
Shortness of Breath on	☐ Yes | ☐ No
exertion Cough	☐ Yes | ☐ No
Cough with Sputum	☐ Yes | ☐ No
Sleep Apnea	☐ Yes | ☐ No
Use a C-PAP Machine	☐ Yes | ☐ No

GASTROINTESTINAL

Jaundice	☐ Yes | ☐ No
Gallstone	☐ Yes | ☐ No
Liver Disease	☐ Yes | ☐ No
(Cirrhosis) Hepatitis	☐ Yes | ☐ No
Ulcers	☐ Yes | ☐ No
Hiatal Hernia	☐ Yes | ☐ No
Heartburn	☐ Yes | ☐ No

SKIN

Cancer	☐ Yes | ☐ No
Radiation	☐ Yes | ☐ No
Atypical Skin Lesions	☐ Yes | ☐ No

ENDOCRINE

Diabetes	☐ Yes | ☐ No
Hyperthyroidism	☐ Yes | ☐ No
Hypothyroidism	☐ Yes | ☐ No
Hypoglycemia High	☐ Yes | ☐ No
Cholesterol	☐ Yes | ☐ No

PSYCHIATRIC

Depression	☐ Yes | ☐ No
Anxiety	☐ Yes | ☐ No
Psychiatric Care	☐ Yes | ☐ No
Obsessive Compulsive	☐ Yes | ☐ No
Disorder	

NEUROLOGICAL

Stroke	☐ Yes | ☐ No
Seizures	☐ Yes | ☐ No
Fainting	☐ Yes | ☐ No
Dizziness	☐ Yes | ☐ No
Headache	☐ Yes | ☐ No
Sciatica	☐ Yes | ☐ No
Herniated disc	☐ Yes | ☐ No
Arthritis	☐ Yes | ☐ No
Rheumatoid	☐ Yes | ☐ No

HEMATOLOGIC/ONCOLOGIC

Bleeding Tendency	☐ Yes | ☐ No
Easy Bruising	☐ Yes | ☐ No
Anemia	☐ Yes | ☐ No
Sickle Cell Disease	☐ Yes | ☐ No
Blood clots in legs	☐ Yes | ☐ No
Blood clots in lungs	☐ Yes | ☐ No
Radiation Therapy	☐ Yes | ☐ No

EYES

Cataracts	☐ Yes | ☐ No
Glaucoma	☐ Yes | ☐ No
Dry Eyes	☐ Yes | ☐ No
Contacts	☐ Yes | ☐ No

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HIPAA AUTHORIZATION
FOR USE OR DISCLOSURE
OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____

I. My Authorization

I authorize the Eye Clinic of Florida to disclose my health information, either in person or over the phone, to the person(s) listed below:

Name:_____ Phone:_____ Relation:_____
Name:_____ Phone:_____ Relation:_____
Name:_____ Phone:_____ Relation:_____

Reviewed - No Changes: (Signature Required)	Date

II. My Rights

I understand that I have the right to revoke this authorization, by certified letter, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

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If the patient is a minor or unable to sign please complete the following:

- ☐ Patient is a minor: _____ years of age
- ☐ Patient is unable to sign because:

_____

Signature of Authorized Representative: _____ Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

- ☐ Parent
- ☐ Legal Guardian
- ☐ Court Order
- ☐ Other:

_____

III. Additional Consent for Certain Conditions

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

- ☐ I consent to have the above information released.
- ☐ I do not consent to have the above information released.

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

- ☐ I consent to have the above information released.
- ☐ I do not consent to have the above information released.

*Signature of Patient or Authorized Representative:*_____

Date: _____ *Time:* _____

YOU CAN REQUEST A COPY OF OUR HIPAA PRIVACY AGREEMENT AT CHECK-IN.

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Cancellation Policy

If you need to cancel and appointment, please do so at least 24 hours in advance by calling (813) 650-0085.

Any patient who misses an appointment without 24 hours advance notice will incur a charge of one session.

Any patient who cancels an appointment within the 24-hour limit will be charged $50.

Any patient who misses more than three appointments are subject to dismissal from the practice.

Waivers to this policy are granted at the sole discretion of Tampa Laser Hair Removal. By signing below, I acknowledge awareness of this cancelation policy.

_____

Name of Patient (please print)

_____ _____

Signature of Patient Date

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Financial Policy

For all cosmetic patients during your visit, you will be given a fee estimate for your proposed aesthetic procedure(s). This quote will include fees for the Same Day Surgery Center and fees for the Anesthesiologist, as well as any special equipment fees or assistant fees. Please note that Dr. Ahad Mahootch's portion of the quote is good for 90 days only. If you choose to schedule the procedure more than 90 days in the future, it is possible that the fee will be different than the original quote. Payment for surgery may be made by cash, major credit card, cashiers check, or personal check. We also offer patient financing through Care Credit. Payment of non-surgical treatments such as BOTOX®, filler, AGNES, etc. are made at the time of service by cash or credit card. At times, a revision or "touch up" procedure may be desired. Should that be the situation, you the patient will be responsible for additional fees including but not limited to Operating Room or Anesthesia.

If you are adding on cosmetic procedure to one that is covered by insurance, you will be responsible for the co-pay and the payment of physician fees to be paid a week prior to surgery. The rest of the cosmetic surgery can be paid at the Same Day Surgery Center the day of surgery.

Dr. Mahootchi is not responsible for refunding any surgical fees or rescheduling fees that result from a patient's non-compliance. The failure to follow pre-surgical instructions includes: nicotine, alcohol, or drug use, failure to avoid or to take specific medications as instructed, and failure to follow day of surgery instructions. Any surgical procedure rescheduled by the patient less than fourteen days prior to surgery or as the result of patient non-compliance, will incur a surgeon's rescheduling fee; this does not include fees that may be charged by the surgical facility. All fees must be paid prior to confirming any new surgical date.

We encourage you to contact our office staff for any questions that you may have, so that this policy may be clarified for you prior to scheduling any procedures. We have found that most patients are pleased to have all details known prior to scheduling.

Statement of Financial Responsibility

"I, the undersigned, have read the above and understand that I am responsible for all medical and surgical charges incurred by myself or my dependents. I authorize the release of any medical information necessary to process any claims that are processed on my behalf by the office of Dr. Ahad Mahootchi. I understand that my medical insurance contract is between my insurance company and myself and that the failure of the insurance company to pay my claim does not absolve my financial responsibility to Dr. Ahad Mahootchi. All court and attorney fees or other fees associated with the collection of my account are my financial responsibility."

_____	_____	_____/_____/_____
Name	Signature	Date

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Model Release: Agreement and Authorized for Model to be in Media

I, the "Model", consent to the taking of photographs or videotapes of myself or parts of my body by Dr. Ahad Mahootchi, or his designee, in connection with any and/or all my plastic surgery procedure(s) to be performed by Dr. Ahad Mahootchi.

BETWEEN:

Florida Face and Body of 6739 Gall Blvd. Zephyrhills, Florida (the "Artist)

AND:

_____of _____
Name Address

_____,_____ (the "Model").
City State

BACKGROUND:

A. The Artist may choose or is currently engaged in the business of creating media, which includes but is not limited to engaging in the following activities for personal and commercial gain: film/video editing, production; photography, photo editing, photo production. These pictures may be used for Facebook, our Google Page, Yelp, Instagram and marketing materials.
B. The Model consents to being a subject of the Artist in media. The Model will allow the Artist to capture images, sound recording and videos.

WHEREBY:
Check One:

☐ ALL MEDIA: Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Florida Face and Body, can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films and internet in order to inform the public about plastic surgery methods. Further, I release and discharge Florida Face and Body, any employees and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party. This information may identify the procedure performed.

☐ Medical Care Only: Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Florida Face and Body. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Florida Face and Body.

_____ _____ _____/_____/_____
Name Signature Date

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Patient Care Agreement

Dear Patient,

Welcome to Florida Face and Body. We hope to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health", we ask you to participate in your care in the following ways:

I Will Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. I will make every effort to reschedule missed appointments as soon as possible.

I Will Inform My Doctor if I Decide *Not* to Follow His Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, seek an explanation, report symptoms, or discuss concerns. If you need more information about your health or condition, please ask.

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