ELITE PLASTIC SURGERY
AND
RESTORATIVE BREAST CENTER

Rozbeh Torabi, MD • Tim Matatov, MD • Oren Tessler, MD, MBA, FACS • Joseph Zakhary, MD
10910 N. Tatum Blvd, Suite B-100, Phoenix, AZ 85028 • Tel: (480) 291-6895 • Fax: (480) 948-3750

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

HOME PHONE: _____ WORK PHONE & EXT: _____ CELL PHONE: _____

EMAIL ADDRESS: _____ MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W

OCCUPATION: _____ EMPLOYER NAME: _____

CONTACT PREFERENCE: ☐ HOME ☐ WORK ☐ CELL ETHNICITY (OPTIONAL): ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO

RACE (OPTIONAL): ☐ AFRICAN AMERICAN ☐ ASIAN ☐ ASIAN INDIAN ☐ NATIVE AMERICAN ☐ PACIFIC ISLANDER ☐ WHITE

SPOUSE/SIGNIFICANT OTHER OR PARENT NAME: _____ DATE OF BIRTH: _____

WORK PHONE & EXT.: _____ CELL PHONE: _____

OCCUPATION: _____ EMPLOYER NAME: _____

EMERGENCY CONTACT (OTHER THAN SPOUSE/SIGNIFICANT OTHER): _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE & EXT: _____ CELL PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: _____

PREFERRED PHARMACY: _____ **PHONE NUMBER & LOCATION:** _____

HOW WERE YOU REFERRED TO ELITE PLASTIC SURGERY/RESTORATIVE BREAST CENTER?

☐ YELP ☐ INTERNET SEARCH ☐ FRIEND/FAMILY MEMBER ☐ PRIMARY CARE PHYSICIAN ☐ GOOGLE

☐ PLEASE EXPLAIN: _____

INSURANCE INFORMATION

☐ **COSMETIC CONSULT**

*****WE MUST MAKE A COPY OF THE FRONT & BACK OF CARD(S) AT TIME OF CHECK IN******

MY **PRIMARY** INSURANCE POLICY IS THROUGH: ☐ SELF ☐ MY EMPLOYER ☐ SPOUSE'S EMPLOYER ☐ STATE/FEDERAL

INSURANCE COMPANY NAME: _____

POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____

ID#: _____ GROUP#: _____ S.S.# OF POLICY HOLDER: _____

CLAIMS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE PHONE: _____ RELATIONSHIP TO POLICY HOLDER: _____

MY **SECONDARY** INSURANCE POLICY IS THROUGH: ☐ SELF ☐ MY EMPLOYER ☐ SPOUSE'S EMPLOYER ☐ STATE/FEDERAL

INSURANCE COMPANY NAME: _____

POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____

ID#: _____ GROUP#: _____ S.S.# OF POLICY HOLDER: _____

CLAIMS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE PHONE: _____ RELATIONSHIP TO POLICY HOLDER: _____

I certify the above information is correct and understand I am required to provide a photo ID for the protection of my personal information:

_____ _____

PATIENT SIGNATURE/GUARDIAN SIGNATURE IF UNDER 18 DATE

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PATIENT HEALTH HISTORY QUESTIONNAIRE

PRINT PATIENT NAME: _____ DATE OF BIRTH: _____

WHAT IS THE REASON YOU'RE BEING SEEN TODAY?

DATE OF INJURY?: _____

HEIGHT: _____

WEIGHT: _____

BMI: _____

PAST SURGERIES

☐ SEE LIST

IF NONE WRITE '**NONE**' HERE: _____

TYPE: _____ DATE: _____ PHYSICIAN: _____

TYPE: _____ DATE: _____ PHYSICIAN: _____

TYPE: _____ DATE: _____ PHYSICIAN: _____

CURRENT MEDICATIONS

☐ SEE LIST

IF NONE WRITE '**NONE**' HERE: _____

NAME: _____ DOSE/HOW OFTEN: _____ FOR? _____

NAME: _____ DOSE/HOW OFTEN: _____ FOR? _____

NAME: _____ DOSE/HOW OFTEN: _____ FOR? _____

MEDICATION ALLERGIES

☐ SEE LIST

IF NONE WRITE '**NONE**' HERE: _____

NAME: _____ TYPE OF REACTION: _____

NAME: _____ TYPE OF REACTION: _____

NAME: _____ TYPE OF REACTION: _____

PAST MEDICAL HISTORY

	NO	YES	PLEASE EXPLAIN, IF YES:
ANEMIA			
BLADDER			
BLEEDING/CLOTTING			
BLOOD DISORDER			
BOWEL			
CANCER			
COPD			
DIABETES			
FIBROMYALGIA			
HEADACHES			
HEARING PROBLEMS			
HEART ATTACK			
HEART PROBLEMS			
HERNIA			
KIDNEY			
LIVER/HEPATITIS			
MENTAL ILLNESS			

PAST MEDICAL HISTORY (continued)

	NO	YES	PLEASE EXPLAIN, IF YES:
NEUROLOGICAL			
OSTEOPOROSIS			
PAST AUTO ACCIDENT			
RESPIRATORY/LUNG			
SEASONAL ALLERGIES			
SEIZURES			
STROKE: CVA/TIA			
SKIN			
STOMACH/INTESTINES			
THYROID			
ULCERS			
VISION			
OTHER:			

DATE OF LAST MENSTRUAL CYCLE:____________

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER ☐ DIVORCED ☐ WIDOWED

CURRENT OCCUPATION: ________________________________

STRESS LEVEL: ☐ LOW ☐ MODERATE ☐ HIGH

EXERCISE LEVEL: ☐ NONE ☐ OCCASIONAL ☐ MODERATE ☐ HIGH

CAFFEINE INTAKE: ☐ NONE ☐ OCCASIONAL ☐ MODERATE ☐ OFTEN

SMOKING STATUS: ☐ NEVER ☐ FORMER ☐ CURRENT: ____________ HOW OFTEN? ____________

ALCOHOL INTAKE: ☐ NONE ☐ OCCASIONAL ☐ MODERATE TIMES A WEEK: ☐ 1-2 ☐ 3-4 ☐ 5+

ILLICIT DRUG USE: ☐ NEVER ☐ FORMER ☐ CURRENT: TYPE: ____________ HOW OFTEN? ____________

EXPOSURE TO CHEMICALS OR RADIATION? ☐ YES ☐ NO

DEAF OR DIFFICULTY HEARING? ☐ YES ☐ NO IF YES, WHEN: ____________

IS A BLOOD TRANSFUSION ACCEPTABLE IN AN EMERGENCY? ☐ YES ☐ NO

FAMILY HISTORY

RELATIONSHIP	HEALTH PROBLEM	ONSET AGE	AGE OF DEATH
	☐ THYROID ☐ ALLERGIES ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ EPILEPSY ☐ STROKE ☐ HEART DISEASE ☐ MENTAL ILLNESS ☐ BLOOD DISEASE ☐ HIGH CHOLESTEROL ☐ OTHER: ____________ ☐ CANCER: TYPE: ____________		
	☐ THYROID ☐ ALLERGIES ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ EPILEPSY ☐ STROKE ☐ HEART DISEASE ☐ MENTAL ILLNESS ☐ BLOOD DISEASE ☐ HIGH CHOLESTEROL ☐ OTHER: ____________ ☐ CANCER: TYPE: ____________		
	☐ THYROID ☐ ALLERGIES ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ EPILEPSY ☐ STROKE ☐ HEART DISEASE ☐ MENTAL ILLNESS ☐ BLOOD DISEASE ☐ HIGH CHOLESTEROL ☐ OTHER: ____________ ☐ CANCER: TYPE: ____________		

PREVIOUS DIAGNOSTIC STUDIES

MRI DATE: ____________ LOCATION: ____________

CT-SCAN DATE: ____________ LOCATION: ____________

X-RAYS DATE: ____________ LOCATION: ____________

EMG/NCS DATE: ____________ LOCATION: ____________

MAMMOGRAM DATE: ____________ LOCATION: ____________

I certify that the above is true and correct to the best of my knowledge:

____
PRINT PATIENT NAME

________________________________ ____________
PATIENT SIGNATURE/GUARDIAN SIGNATURE IF UNDER 18 DATE

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REVIEW OF SYSTEMS

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST 30 DAYS

CONSTITUTIONAL

- ☐ FEVER
- ☐ NIGHT SWEATS
- ☐ SIGNIFICANT WEIGHT GAIN
- ☐ SIGNIFICANT WEIGHT LOSS
- ☐ EXERCISE INTOLERANCE
- ☐ MALAISE

CARDIOVASCULAR

- ☐ CHEST PAIN
- ☐ ARM PAIN ON EXERTION
- ☐ SHORTNESS OF BREATH WHEN WALKING
- ☐ SHORTNESS OF BREATH WHEN LYING DOWN
- ☐ PALPITATIONS
- ☐ KNOWN HEART MURMUR
- ☐ ANKLE SWELLING

GENITOURINARY

- ☐ INCONTINENCE
- ☐ DIFFICULTY URINATING
- ☐ HEMATURIA
- ☐ INCREASED URINATING FREQUENCY

RESPIRATORY

- ☐ COUGH
- ☐ WHEEZING
- ☐ SHORTNESS OF BREATH
- ☐ COUGHING UP BLOOD
- ☐ SLEEP APNEA

GASTROINTESTINAL

- ☐ ABDOMINAL PAIN
- ☐ NAUSEA
- ☐ VOMITING
- ☐ CONSTIPATION
- ☐ ABNORMAL APPETITE
- ☐ DIARRHEA
- ☐ VOMITING BLOOD
- ☐ DYSPEPSIA
- ☐ GERD

MUSCULOSKELETAL

- ☐ MUSCLE ACHES
- ☐ MUSCLE WEAKNESS
- ☐ ARTHRALGIAS/JOINT PAIN
- ☐ BACK PAIN
- ☐ SWELLING IN EXTREMITIES
- ☐ NECK PAIN
- ☐ DIFFICULTY WALKING
- ☐ CRAMPS
- ☐ OSTEOPOROSIS
- ☐ FRACTURES

INTEGUMENTARY

- ☐ ABNORMAL MOLE
- ☐ JAUNDICE
- ☐ RASHES
- ☐ LACERATION
- ☐ NON-HEALING AREAS
- ☐ CHANGES IN HAIR/NAILS
- ☐ PSORIASIS
- ☐ CHANGE IN SKIN COLOR
- ☐ BREAST LUMP

NEUROLOGIC

- ☐ LOSS OF CONSCIOUSNESS
- ☐ WEAKNESS
- ☐ NUMBNESS
- ☐ SEIZURES
- ☐ DIZZINESS
- ☐ MIGRAINES
- ☐ HEADACHES
- ☐ TREMOR
- ☐ GAIT DYSFUNCTION
- ☐ PARALYSIS

PSYCHIATRIC

- ☐ DEPRESSION
- ☐ SLEEP DISTURBANCE
- ☐ FEELING UNSAFE IN A RELATIONSHIP
- ☐ ALCOHOL ABUSE
- ☐ ANXIETY
- ☐ HALLUCINATIONS
- ☐ SUICIDAL THOUGHTS
- ☐ MOODSWINGS
- ☐ MEMORY LOSS
- ☐ AGITATION
- ☐ DEMENTIA
- ☐ DELIRIUM

ENDOCRINE

- ☐ FATIGUE

HEMATOLOGIC/ LYMPHATIC

- ☐ SWOLLEN GLANDS
- ☐ BRUISING
- ☐ EXCESSIVE BLEEDING
- ☐ ANEMIA

☐ NONE OF THE ABOVE

☐ OTHER: _____

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AUTHORIZATION TO SHARE PROTECTED INFORMATION

Elite Plastic Surgery & Restorative Breast Center **DOES NOT** release private health information to anyone without specific written authorization to do so.

Protection of confidential information also applies to spouses, partners, and parents (including parents of minors in certain circumstances) in accordance with state and federal laws.

Please mark one:

_____ **I do not wish to have my personal and confidential information shared with anyone other than myself.**

_____ I am giving Elite Plastic Surgery & Restorative Breast Center permission to share my personal, protected and confidential information with the individuals I have listed below. I understand this authorizes complete access to the following protected information including, but not limited to: laboratory results, radiology results, physician notes, assessments, findings, and opinions, as well as, financial information relating to account status, collection status, and payment history:

NAME: _____ RELATIONSHIP: _____ DOB: _____

NAME: _____ RELATIONSHIP: _____ DOB: _____

NAME: _____ RELATIONSHIP: _____ DOB: _____

This authorization will remain in effect ***indefinitely*** unless a specific date is written here: _____

I understand this authorization may be revoked or revised at any time by me in writing. I understand Elite Plastic Surgery & Restorative Breast Center cannot be held responsible for information released under this agreement prior to the receipt of a written revocation and I will not hold Elite Plastic Surgery & Restorative Breast Center responsible for such disclosures.

I understand I will need to provide separate written authorization to receive copies of my protected health information. Photocopying fees will apply unless records are sent directly to another physician.

I have read this agreement and understand my personal protected health information **will not** be shared unless I have specifically indicated the approved individuals above.

_____
PRINT PATIENT NAME

_____ _____
PATIENT SIGNATURE/GUARDIAN SIGNATURE IF UNDER 18 DATE

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PATIENT PHOTOGRAPH RELEASE FORM

PATIENT'S NAME:_____ DATE OF BIRTH:_____

PHOTOGRAPH CONSENT AND RELEASE

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of Elite Plastic Surgery & Restorative Breast Center medical staff. I hereby give my consent for Elite Plastic Surgery & Restorative Breast Center to use the photographs under one of the following circumstances.

PLEASE INITIAL ONLY ONE OF THE FOLLOWING:

_____ **Internet:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Elite Plastic Surgery & Restorative Breast Center can be used on the company's website in order to inform the public about plastic surgery methods. Further, I release and discharge Elite Plastic Surgery & Restorative Breast Center any employees of Elite Plastic Surgery & Restorative Breast Center, and the American Society of Plastic Surgeons; 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 or any other identifying marks at any time during any use or publication of these materials by any party.

_____ **All Media:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Elite Plastic Surgery & Restorative Breast Center, can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Elite Plastic Surgery & Restorative Breast Center, any employees of Elite Plastic Surgery & Restorative Breast Center, and the American Society of Plastic Surgeon`s; 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.

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Elite Plastic Surgery & Restorative Breast Center. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Elite Plastic Surgery & Restorative Breast Center.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

_____ _____

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NOTICE OF PRIVACY PRACTICES

The privacy of medical information is very important to us. We are committed to protecting the personal information of our patients. A medical record is prepared and maintained by our office on all patients to ensure quality care and to comply with certain legal requirements. Under the HIPAA Privacy Rule, we are required to keep each patient's medical information private, give notice describing our legal duties, privacy practices, and patient's rights regarding their medical record, and follow terms of the privacy notice now in effect. This notice is kept on file in the front office and with the compliance officer. Each patient is given a copy of the notice to read, and must sign an acknowledgement of their awareness of the policy. This is placed in their medical record. We reserve the right to make changes to the privacy policies at any time as permitted by the law. Patients will be notified of changes.

USE AND DISCLOSURE OF MEDICAL INFORMATION

We will not use or disclose any private medical information for any purpose not listed without specific written authorization by the patient or legal guardian. The following is a list of how we are permitted to use medical information without the written consent of the patient.

1. Treatment-We may disclose information to doctors, nurses, technicians, medical students, or others who are taking care of the patient. We may also share information with other providers to assist them in the treatment of a mutual patient.

2. Payment-Medical information may be disclosed when requested by insurance companies for payment of claims. Limited information can be disclosed to collection agency for purposes of receiving payment from the patient. Worker's compensation claims are subject to the laws set forth by the state and may require the release of protected health information in order for claims to be paid.

3. Health Care Operations-Use and disclosure for operations includes improving quality, evaluating employee performance, training purposes and obtaining accreditation, licenses, and credentials needed to perform day to day business.

4. Notification-Medical information may be released to notify or help notify a family member, a personal representative, or person responsible for the patient's care about the location of the patient, general condition, or death. If the patient is present then permission will be obtained or documented. In case of an emergency, when the patient is unable to give permission, only the information that is necessary for treatment will be disclosed according to our professional judgment.

5. Fundraising-We limit our use of medical information for affiliated fundraising foundations to general, not personal, terms. In any fundraising materials, we provide a description of how the patient may choose not to receive fundraising materials.

6. Research-Medical information for research purposes in limited circumstances where approved by a review board that has examined the research proposal and established protocols to ensure the privacy of the information.

7. Funeral Director, Coroner, Medical Examiner-Information may be released to assist in performing their duties for a patient that has died.

8. Court Orders, Judicial and Administrative Proceedings-Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share medical information about a patient. We may also share limited information with law enforcement concerning a suspect, fugitive, material witness, crime victim, missing person, or inmate under lawful custody of a correctional facility. We may also disclose information to law enforcement when required by certain laws such as reporting of certain types of wounds, crimes on premises, and crimes in emergencies.

9. Public Health Activities- As required by law, medical information may be disclosed when preventing or controlling a disease, injury or disability, including child abuse or neglect. Information may also be disclosed to the PDA for purposes of reporting adverse events associated with product defects or problems, and to enable product recalls. We may also, when authorized by law to do so, notify persons who may have been exposed to a communicable disease or otherwise be at risk of spreading or contracting a disease or condition.

10. Victims of Abuse, Neglect or Domestic Violence-We may disclose medical information to appropriate authorities if we reasonably believe that a person is a possible victim of abuse, neglect, domestic violence, or other crimes. We may share information if it is necessary to prevent a serious threat to the health or safety of the patient or others.

11. Health Oversight Activities-We may disclose information to an agency providing health oversight activities authorized by law including civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions.

Complaints should be filed to:
Elite Plastic Surgery & Restorative Breast Center
Attn: HIPAA Compliance Officer
10910 N Tatum Blvd Ste. B-100, Phoenix, AZ 85028

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

PRINT PATIENT NAME

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Revised 09/2019 **POS** Reorder # 1815069

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NARCOTIC CONTRACT AND PRESCRIPTION REFILL POLICY

1. I agree to allow 24 hours for prescription(s) to be called in.
2. I understand that prescription(s) requested after 4:00pm will not be received until the next business day.
3. I understand that **NO REFILLS** will be given.
4. I agree to take all medication exactly as instructed. I am NOT allowed to change the dosage amounts or alter the time schedule of taking the medication without first speaking to my physician.
5. I understand that narcotics and non-narcotics medications will not be phoned in after hours or on the weekends.
6. Patients may be terminated from the practice within 30 days' notice for noncompliance in taking their medications. In order to ensure compliance, Elite Plastic Surgery & Restorative Breast Center reserves the right to perform random drug screen monitoring on patients who require prescription narcotic medications, as required by law. Refusal to cooperate with a drug screen will likewise constitute a basis for termination from the practice. I certify that I will voluntarily provide a fresh, unadulterated saliva or urine specimen for testing.
7. Elite Plastic Surgery & Restorative Breast Center will NOT refill prescriptions that have been lost or misplaced.
8. I will keep all appointments as recommended.
9. I will not give, trade or sell medications.
10. The following are specific (but not exclusive) grounds for immediate termination from the practice:
    a. I agree to give written/verbal notice if I am currently receiving narcotics from any other physician while under Elite Plastic Surgery & Restorative Breast Center care.
    b. Altering or forging of a prescription. This is a felony and will be reported.
11. I am aware that most of the manufacturers of drugs used to treat chronic pain management are against the operations of heavy equipment, which includes driving a motor vehicle. I am aware if I choose to drive a vehicle I could be charged with a DUI.
12. I will not combine any narcotic medications with the consumption of alcohol.
13. I understand that only one pharmacy may be used for filling, refilling my medications. I agree to update my records at Elite Plastic Surgery & Restorative Breast Center if my pharmacy information changes.

My Pharmacy's Name and Location is: _____

Pharmacy's Phone Number: _____

I have read, understand and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe narcotic medications to treat my pain. I acknowledge that I have a right to a paper copy of this signed agreement upon request, and I have had the opportunity to ask questions and receive answers to my satisfaction. I hereby allow the clinical staff of Elite Plastic Surgery & Restorative Breast Center to view my medication history from external sources, including but not limited to the Arizona State Board of Pharmacy.

_____
PRINT PATIENT NAME

_____ _____
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