JAIBAJI
PLASTIC SURGERY • CORONADO

MONEER JAIBAJI, MD,
PLASTIC AND RECONSTRUCTIVE SURGERY
1001 B Avenue, Suite #108
Coronado, CA 92118
Tel: 619-522-0821 | Fax: 619 878 2820 | www.mjplasticsurgery.com

PATIENT INFORMATION

Date:_____

Last Name:_____First Name:_____ DOB:_____Age:____

Address:_____ City:_____ State:_____ ZIP_____

Telephone:_____Cell:_____

Marital Status: Single Married Divorced Widowed Sex_____ Primary Care:_____

Okay To Leave Messages Regarding Appointment or Tests Results Yes _____ No _____

Person Healthcare Info May Be Given to Name:_____Telephone:_____

Employer:_____ Position_____ Telephone_____

Address:_____ City:_____ State:_____ ZIP_____

How Were You Referred To Our Office_____E-Mail Address_____

Reason for visit:_____

INSURANCE INFORMATION

Primary Insurance_____

Subscriber's Name_____ Policy #:_____ Group:_____

Secondary Insurance _____

Subscriber's Name_____ Policy #:_____ Group:_____

Person to Notify In Case Of an Emergency:

Name:_____ Phone#:_____ Relationship:_____

ASSIGNMENT OF BENEFITS AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Carrier
and assign directly to Dr. Moneer Jaibaji all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, copays, deductibles, co-insurances or non-covered services. I hereby authorize Dr. Jaibaji to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

Patient Signature:_____ Date:_____

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Patient Health History

YES NO **HAVE YOU EVER HAD PLASTIC SURGERY?**
(Describe)

YES NO **HAVE YOU EVER HAD ANY OTHER SURGERY?**
(Describe)

YES NO **DO YOU HAVE ANY CURRENT MEDICAL PROBLEMS?**
(Please Explain)

YES NO **DO YOU HAVE ANY SEASONAL ALLERGIES?**
(Hay fever, etc., please List)

YES NO **ARE YOU ALLERGIC TO ANY MEDICATIONS?**
(Please List)

YES NO **DO YOU HAVE ANY SKIN ALLERGIES?**
(Adhesive tape, latex, lotions, etc. ….. Please List)

LIST **WHAT MEDICATIONS DO YOU TAKE NOW?**
(Please Do Not Omit Any Medication)

MEDICATION DOSAGE FREGUENCY PURPOSE

_____

_____

_____

_____

YES NO **ARE YOU CURRENTLY TAKING ANY HERBAL OR HOMEOPATHIC MEDICATION?** (Please List)

_____

_____

LIST **FAMILY HISTORY/ MEDICAL PROBLEMS**

_____

_____

YES NO **ARE YOU CURRENTLY UNDER THE CARE OF, OR DO YOU HAVE AN INTERNIST OR FAMILY PHYSICIAN?**

Name: _____

Address: _____

Telephone: _____

DESCRIBE YOUR HEALTH STATUS: ____ EXCELLENT _____GOOD ____ FAIR _____POOR

_____ HEIGHT _____ WEIGHT

MARK ANY SYMPTOMS OR ILLNESS, YOU HAVE EXPERIENCED, WHICH MAY HAVE A SIGNIFICANT IMPACT ON YOUR HEALTH:

GENERAL ….(Normal)
____ Frequent Sore Throat
____ Fever
____Weigh lose/gain
____Fatigue
____Depression
____Nervousness
____Trouble Sleeping

HEAD…. (NORMAL)
____ Migraine Headaches
____ Tension Headaches
____ Head Injury

EARS ….(NORMAL)
____ Decreased Hearing
____ Pain
____ Drainage
____ Noises / Tinnitus
____ Balance trouble/ Vertigo

EYES ….(NORMAL)
____ Decreased Vision
____ Pain
____ Double Vision
____ Dry Eyes
____ Glaucoma
____ Cataracts
____ Frequent Itching
____ Frequent Irritation
____ Syorgen's Syndrome

NOSE & THROAT (NORMAL)
____ Frequent Sore Throat
____ Hoarseness
____ Nasal Stuffiness
____ Nasal Allergies
____ Nose Bleeds
____ Sinus Trouble
____ Snoring

MOUTH…. (NORMAL)
____ Dental Problems
____ Trouble Chewing
____ Dentures

ENDOCRINE….(NORMAL)
____ Thyroid Disease
____ Diabetes

HEART…..(NORMAL)
____ High blood pressure
____ Heart trouble/ Disease
____ Heart Attack
____ Rheumatic fever
____ Heart murmur
____ Chest Pain /Angina
____ Palpitations
____ Irregular Heart Beat
____ Mitral Valve Prolepses

LUNGS ….(NORMAL)
____ Asthma
____ Pneumonia
____ Tuberculosis
____ Shortness of Breath
____ Emphysema
____ Trouble Breathing

LIVER …. (NORMAL)
____ "Yellow" Jaundice
____ Hepatitis

ARMS & LEGS…. (NORMAL)
____ Pulmonary Embolism
____ Arthritis
____ Phlebitis
____ Varicose Veins
____ Raynaud 's phenomenon

BACK….(NORMAL)
____ Back Aches / Stiffness
____ Back Injury

DIGESTIVE…. (NORMAL)
____ Trouble Swallowing
____ Heartburn / Ulcer
____ Frequent Nausea
____ Frequent Vomiting
____ Frequent Diarrhea
____ Frequent Constipation
____ Irritable Bowel

URINARY….(NORMAL)
____Difficulty Urinating
____ Kidney Stones
____ Kidney Disease

NEUROLOGICAL….(NORMAL)
____ Stroke
____ Seizure Disorder
____ Memory Loss
____ Fainting
____ Paralysis

BLEEDING…. (NORMAL)
____ Easy Bruising
____ Excess Bleeding Post-Op
____ Anemia / Thalassemia
____ Blood Transfusion

REPRODUCTIVE…. (NORMAL)
____ Sexually Transmitted Disease
____ Currently Pregnant

SKIN …. (NORMAL)
____ Dermabrasion
____ Radiation Treatment
____ Acne
____ Chemical Peel
____ Moles
____ other skin Lesions
____ Lupus
____ Skin Cancer
____ Sun Damage
____ Scars
____ Electrolysis
____ Blotches
____ Psoriasis
____ Eczema

NECK…. (NORMAL)
____ Swollen Glands
____ Enlarged Thyroid

HABITS…..
____Tobacco ____ packs/day
____Wine ____ glasses/day
____ Beer ____ glasses/day
____ Spirits ____ glasses/day

PATIENT PRIVACY and CONSENT

FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby consent to the use or disclosure of my protected health information by the practice of Moneer Jaibaji, M.D., hereinafter referred to as ("Practice"), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document. I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. I understand that payment for such procedures may be requested in advance of any treatment. I understand there are no warrantees, implied or otherwise, to the outcomes of any treatments or procedure.

I have been offered, read and/or understand the Practice's *Notice of Privacy Practices*, which has been offered to me by the practice, prior to signing this document. I understand that patient privacy rights and disclosure varies state by state.

I also understand that the *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance o health care operations. This *Notice of Privacy Practices* also describes my rights and the practice's duties with respect to my protected health information. The *Notice of Privacy Practices* for the Practice available at the offices of the Practice: MONEER JAIBAJI, M.D.

Terms of the *Notice of Privacy Practices* may change. If changes are made, I may obtain a revised *Notice of Privacy Practices* by: calling the offices of the practice requesting a revised copy be sent in the mail, or by requesting one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative if the Patient is a Minor — Date

_____

Printed Name of Patient or Personal Representative

_____

Relationship of Personal Representative to the Patient

_____

Signature of Practice Representative and Witness