COSMETICARE
PLASTIC SURGERY CENTER & MEDSPA

1101 BAYSIDE DR. SUITE 100
NEWPORT BEACH, CA 92625
949.718.6900

BASIC INFORMATION

LAST NAME	FIRST NAME	M.I.	BIRTHDATE	GENDER F / M

STREET ADDRESS	CITY	STATE	ZIP CODE

EMAIL ADDRESS	CELL PHONE	HOME PHONE

IN CASE OF EMERGENCY

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

COSMETIC CONCERNS

FACE

- ☐ Wrinkles
- ☐ Skin Texture
- ☐ Skin Discoloration
- ☐ Oily Skin or Dry Skin
- ☐ Unwanted Hair
- ☐ Visible Veins
- ☐ Thin Lips
- ☐ Gummy Smile

BODY

- ☐ Loose Skin
- ☐ Unwanted Tattoo
- ☐ Look of Buttocks
- ☐ Leg Veins
- ☐ Stretch Marks
- ☐ Look of Chest
- ☐ Look of Upper Arms
- ☐ Look of Legs

FEET

- ☐ Unattractive toenails
- ☐ Unattractive feet
- ☐ Unattractive toes
- ☐ Bunions
- ☐ Hammertoes
- ☐ Skin Condition
- ☐ Foot or ankle pain
- ☐ Athlete's foot
- ☐ Corns and Calluses

MEDICAL GRADE SKINCARE

Would you like to be educated on how to take care and improve the appearance of your skin? ☐ Yes ☐ No

PAST MEDICAL & SURGERY HISTORY

- ☐ None
- ☐ Bleeding Disorder
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Cancer
- ☐ Chest Pain / Tightness
- ☐ Diabetes
- ☐ Eczema
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hives
- ☐ Gynecology
- ☐ Kidney Stones
- ☐ Skin Cancer
- ☐ Skin Disease
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ X-ray Therapy
- ☐ Autoimmune Disease (MS, Bell's Palsy)

RECENT EXAMINATIONS

	YES	NO	DATE
Physical Exam			
Chest X-ray			
Mammogram			
EKG			
Labs			

HEIGHT & WEIGHT

Height ft in Weight lb

SURGERY / HOSPITALIZATION	DATE	ANESTHESIA COMPLICATIONS

ALLERGIES IF NONE, PLEASE WRITE "NONE"

CURRENT MEDICATIONS (INCLUDING OVER-THE-COUNTER, PRESCRIPTION, HOLISTIC, AND DIETARY SUPPLEMENTS)	DOSAGE

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FAMILY HISTORY PLEASE LIST ILLNESSES AND WHO HAD IT

SOCIAL HISTORY

How often do you drink alcohol?	/week	Do you have a history of drug abuse?	☐ Yes ☐ No
Do you have a history of alcoholism?	☐ Yes ☐ No	How much coffee do you drink a day?	/day
How often do you use recreational drugs?	/week		

CURRENT TOBACCO USE

- ☐ Non-user
- ☐ Smoker
- ☐ Smokeless tobacco (e.g. chews, snuff, etc.)
- ☐ Ecigarette or other nicotine products

FEMALE QUESTIONS

- ☐ I am pregnant or lactating
- ☐ I am trying to conceive

PATIENT ABILITY TO HEAL

- ☐ Skin appears fragile & burns easily
- ☐ Skin forms thick or raised scarring from cuts or burns
- ☐ I use wax or use depilatories on my face
- ☐ I get cold sores
- ☐ N/A

_______________________________   ____/____/____

SIGNATURE   DATE

Health Care Disclosure Notification

Dear Patient:

Effective April 14, 2003, the Federal Health Privacy Rule must be implemented and we must inform our patients of their rights under this law.

While we have always made every effort to keep all your information confidential, we are now required to inform you of those persons or entities who may have access to your personal and health care information.

1. Employees of CosmetiCare and South Coast Outpatient Surgery Center (limited by job classification)
2. Physicians associated with your treatment or surgical procedure
3. Outside physicians or pathologist who would examine tissue removed
4. Anesthesiologist associated with the Surgery Center
5. Any physician or hospital to whom you are referred by our staff physicians
6. Any independent contractor working with CosmetiCare, i.e. consultants and aestheticians
7. Any independent contractor working with South Coast Outpatient Surgery Center, i.e. , registered and licensed vocational nurses and technologists.
8. Your health insurance provider
9. Designated family members or friends (post surgical)
10. Accrediting agencies
11. Medical staff committees for the purpose of quality assessment and peer review
12. Licensing agencies in response to inquiries
13. Issuance of a subpoena and upon verification of authorization
14. Research - patients who are participating in a clinical study

ALL PATIENTS WILL BE REQUESTED TO SIGN A CONSENT PRIOR TO TREATMENT.

Patient's Rights

1. Patient has the right not to sign consent. However, this would necessitate the physician to refuse treatment.
2. A patient has the right to revoke the consent after receiving treatment.
3. Patient has the right to request restrictions and request confidential communication.
4. Patient has the right to examine and review his or her health information upon written request. This request will be honored within five (5) working days.
5. Patient has the right to request a copy of his or her health information upon written request. The copy will be completed within 15 days of receiving request at a cost to the patient of $ 0.25 per page.
6. Patients have the right to request an amendment to their health information and, if accepted, this will become a part of the complete medical record. Information and procedure to be followed can be received by contacting April Lee at extension 255.
7. Patients who feel their privacy with regards to personal or health care information has been compromised may contact:
   a. April Lee, in this office, at extension 255
   b. Department of Health and Human Services
   c. Office of Civil Rights

NOTICE: By signing this notification you are agreeing that you have been notified of the Federal Health Privacy Rule now in effect.

____
Patient Name (Print)

____
Signature: Patient or Patient's Representative

____
Date

CONSENT FOR THE DICLOSURE OF HEALTH AND PERSONAL INFORMATION

You have already received our Disclosure Notification, which made you aware of the persons and entities whom could possibly have access to your medical information for the purposes of treatment, payment, and health care operations.

As stated in the Notification, you have the right to request restrictions or revoke your consent. If you have any further questions or need clarification, please discuss with a member of our staff.

I consent for the use of my medical/personal information to be used for the purposes outlined in the Disclosure Notification.

I have restrictions: ☐ Yes ☐ No ________ Initial

Please list any restrictions below:

____

____

____

____

Restrictions Approved by Provider: ☐ Yes ☐ No ________ Initial

---

I have read and understand the foregoing Consent for Disclosure.

____
Patient Name (Print)

____
Signature: Patient or Patient's Representative

____
Date

BALBOA SURGERY CENTER

1101 Bayside Drive , Newport Beach, CA 92625

Health Information as of ________________ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient:			
DOB	Age	Marital Status	Weight lbs
What surgery are you considering?			Height ft in

DO YOU NOW OR HAVE YOU EVER HAD……….. (You must circle an answer for each individual item)

Condition		
Chicken Pox	Yes	No
Diptheria	Yes	No
Scarlet Fever	Yes	No
Malaria	Yes	No
Measles	Yes	No
Rheumatic Fever	Yes	No
Typhoid Fever	Yes	No
Jaudice	Yes	No
Personal History of Cancer	Yes	No
Family History of cancer, heart trouble, stroke	Yes	No
Headaches	Yes	No
Dizziness	Yes	No
Tremors	Yes	No
Fainting	Yes	No
Loss of Equilibrium	Yes	No
Loss of Consciousness	Yes	No
Impaired Hearing	Yes	No
Visual Disturbances	Yes	No
Glaucoma or Eye Problems	Yes	No
Chronic Cough	Yes	No
Coughing or Spitting of Blood	Yes	No
Airway Obstruction (Nasal)	Yes	No
Sinus Infection	Yes	No
Postnasal Drip	Yes	No
Wheezing/Asthma	Yes	No
Night Sweats	Yes	No
Weight Loss	Yes	No
Lack of Appetite	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Difficulty Swallowing	Yes	No
Chronic Indigestion	Yes	No
Acid Reflux	Yes	No
Ulcer History	Yes	No
Hemorrhoids	Yes	No
Bleeding	Yes	No
Black Stool	Yes	No
Blood in Urine	Yes	No
Difficulty in Urniation	Yes	No

Condition		
Discharge	Yes	No
Vererneal Disease	Yes	No
Missed or irregular menstrual period	Yes	No
Nipple Discharge (Apart from Normal Lactaton)	Yes	No
Breast Cysts, Tumors, Abscesses	Yes	No
Heart Disease	Yes	No
Chest Pain	Yes	No
Heart Attack	Yes	No
Stroke	Yes	No
Hypertension (High Blood Pressure)	Yes	No
Blood Pressure Abnormalities	Yes	No
Abnormal EKG	Yes	No
Shortness of Breath	Yes	No
Palpitations	Yes	No
Irregular Heart Beats	Yes	No
Angina	Yes	No
Bleeding Tendencies	Yes	No
Pneumonia	Yes	No
Tuberculosis	Yes	No
Pleurisy	Yes	No
Diabetes	Yes	No
Arthritis	Yes	No
Nervous Breakdown	Yes	No
Depression	Yes	No
Seizures	Yes	No
Convulsions	Yes	No
Joint Disorder	Yes	No
Numbness	Yes	No
Paralysis	Yes	No
Pain	Yes	No
Hepatitis	Yes	No
Positive blood test for HIV, AIDS, Hepatitis	Yes	No
Anemia	Yes	No
Alcoholism or Drug Dependency	Yes	No
Drug Habit	Yes	No
Dentures, Bridges, Capped Teeth, or Crowns	Yes	No
Loose Teeth	Yes	No
Sleep Apnea Syndrome	Yes	No
Do you utilize a CPAP Mask & Machine	Yes	No

If you have or had any of the above, please describe:

____

____

____

____

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

____

____

2. Do you have an allergic reaction to any medication? ❐ Yes ❐ No Which? ____________

3. Do you react abnormally to any medication? ❐ Yes ❐ No Which? ____________

4. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?

   ❐ Yes ❐ No If yes, when and where? ____________

5. Have you ever been on cortisone or steroid treatment? ❐ Yes ❐ No When? ____________

6. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

   ❐ Yes ❐ No If so, how much? ____________

7. Do you smoke? ❐ Yes ❐ No If so, how much? ________ For how long? ________

8. Are you pregnant? ❐ Yes ❐ No When was you last normal menstrual period? ____________

9. How many pregnancies? ______ Births? ______ Breast Fed? ❐ Yes ❐ No How long? ______

10. When was your last physical exam? ____________ By whom? ____________

11. When was your last mammogram? ____________ By whom? ____________

12. When and where was your last chest x-ray? ____________ EKG? ____________

13. Who is your personal physician, if any? ____________Please list all physicians presently caring for you.

    ____

14. Have you ever been under psychiatric care? ❐ Yes ❐ No When? ________Why? ________

15. Is there anything else you think the doctor should know? ____________

    ____

16. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

    SURGICAL OPERATIONS (include where, when and why for each surgery): ____________

    ____

    ____

    ____

    HOSPITALIZATIONS (include where, when and why for each admission): ____________

    ____

    ____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: ______________________________ Date: ____________

CosmetiCare
PLASTIC SURGERY CENTER & MEDSPA

Date:

Patient Name:

Email Address:

Phone:

Gender: F / M

Appointment: Yes / No

Interested in:
- ☐ Surgical Treatments
- ☐ Non-Surgical Treatments
- ☐ Financing

SELECT YOUR CONCERNS

Face
- ☐ Acne
- ☐ Acne Scars / Scars
- ☐ Aged Skin
- ☐ Freckles
- ☐ Large Pores
- ☐ Skin Texture
- ☐ Skin Tone
- ☐ Spots, Discoloration
- ☐ Wrinkles

Forehead
- ☐ Angry Look
- ☐ Sagging Brows
- ☐ Uneven Brows
- ☐ Wrinkles

Eyes
- ☐ Dark Circles
- ☐ Eyelash Changes
- ☐ Eyelids are Puffy
- ☐ Lack of Eyelid Crease
- ☐ Sagging Eyelids
- ☐ Sunken, Hollow Eyes
- ☐ Tired Eyes
- ☐ Uneven Eyelids
- ☐ Wrinkles

Nose
- ☐ Nose Shape
- ☐ Nose Size
- ☐ Too Wide

Ears
- ☐ Dislike Shape
- ☐ Oversized Piercing
- ☐ Ears Stick Out Too Much

Cheeks
- ☐ Brown Spots
- ☐ Cheeks Need Definition
- ☐ Redness / Rosacea
- ☐ Cheeks Too Full
- ☐ Wrinkles
- ☐ Volume Loss

Mouth
- ☐ Gummy Smile
- ☐ Lip Too Full
- ☐ Lips Too Thin
- ☐ Crooked Teeth
- ☐ Wrinkles Around Mouth
- ☐ Marionette Lines
- ☐ Nasolabial Folds

Chin / Jawline
- ☐ Chin Too Far Out
- ☐ Excessive Fat
- ☐ Jawline Too Small
- ☐ Jawline Too Wide
- ☐ Lack of Chin
- ☐ Sagging Skin
- ☐ Uneven Jaw / Chin Line
- ☐ Wrinkles

Neck
- ☐ Excessive Fat
- ☐ Excessive Skin
- ☐ Neck Bands
- ☐ Sagging Skin
- ☐ Skin Tone, Discoloration
- ☐ Wrinkles
- ☐ Unwanted Tattoo

Breasts / Chest
- ☐ Breasts Too Small
- ☐ Chest Too Small or Undefined
- ☐ Breasts Uneven
- ☐ Not Enough Cleavage
- ☐ Droopy Breasts
- ☐ Nipple / Areola Issues
- ☐ Breast Shape
- ☐ Breasts Too Large
- ☐ Skin Tone, Discoloration
- ☐ Visible Veins
- ☐ Unwanted Tattoo or Scar

Abdomen
- ☐ Cellulite
- ☐ Love Handles
- ☐ Belly Button Shape
- ☐ Flabby or Sagging Skin
- ☐ Scars
- ☐ Skin Tone, Discoloration
- ☐ Stretch Marks
- ☐ Stubborn, Excessive Fat
- ☐ Unwanted Tattoo

Back
- ☐ Love Handles
- ☐ Cellulite
- ☐ Flabby or Sagging Skin
- ☐ Scars
- ☐ Skin Tone, Discoloration
- ☐ Stretch Marks
- ☐ Stubborn, Excessive Fat
- ☐ Unwanted Tattoo

Arms / Hands
- ☐ Aged Hands
- ☐ Wrinkly Hands
- ☐ Scars on Hands
- ☐ Spots, Discoloration
- ☐ Visible Veins on Hands
- ☐ Unwanted Tattoo on Hands
- ☐ Flabby or Sagging Skin
- ☐ Excessive Arm Fat
- ☐ Scars on Arms
- ☐ Visible Veins on Arms
- ☐ Unwanted Tattoo on Arms

Buttocks
- ☐ Cellulite
- ☐ Butt Too Small or Flat
- ☐ Butt Too Large
- ☐ Flabby or Sagging Skin
- ☐ Scars
- ☐ Stubborn, Excessive Fat
- ☐ Spots, Discoloration
- ☐ Stretch Marks
- ☐ Unwanted Tattoo

Thighs / Legs
- ☐ Cellulite
- ☐ Flabby or Sagging Skin
- ☐ Lack of Calf Volume
- ☐ Scars
- ☐ Spots, Discoloration
- ☐ Stretch Marks
- ☐ Stubborn, Excessive Fat
- ☐ Unwanted Tattoo
- ☐ Visible Veins

OFFICE USE ONLY

TREATMENT PLAN

TOTAL QUOTE

☐ Approved for financing

CosmetiCare®
PLASTIC SURGERY CENTER & MEDSPA

PHOTOGRAPHIC RELEASE AND CONSENT

I grant permission to CosmetiCare, New Look Now, LLC, their respective agents, employees, assignees and/or licensees a complete, exclusive, and irrevocable license to use photographs or images of me, taken by me, or submitted by me, including newly generated images for use in all of CosmetiCare & New Look Now, LLC's publications, including but not limited to brochures, advertisements, materials, newsletters, display boards and electronic versions of the same publications or on CosmetiCare's or New Look Now's websites, or other electronic and other forms or media, and to offer them for use or distribution in other publications, electronic or otherwise, without notifying me. The license granted herein shall be in perpetuity and without limitation, exclusive, and may not be revoked for any reason.

I further agree that CosmetiCare and New Look Now, LLC may license others to use the photographs or any excerpts, and my name and likeness used in or identifying the photographs, and in any related or derivative versions of the photographs, and in any advertising, marketing and promotional materials, of any kind, and without limitation to region or form of media.

I agree to waive and release any and all claims against CosmetiCare and New Look Now, LLC, and their respective agents, employees, assignees and/or licensees relating to my name, my likeness, the photographs referenced herein and their uses and/or distribution in any version or media throughout the universe, including without limitation, any rights and claims relating to royalties or compensation, editing, alteration, copyright, distribution, misappropriation, defamation, libel, false light, rights of privacy and/or publicity.

____
Patient's Signature

____
Witness' Signature

____
Patient's Printed Name

____
Witness' Printed Name

____
Date

____
Date

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitrati

Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim, in the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional stress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration or any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitratiors appointed by the parties within 30 days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. The immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes with this arbitration agreement including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1, and 3333.2. Any party may bring before the arbitrators a motion of summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claims fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature, It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

____
Patient or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: ______________________________
Physician's or Authorized Representative Signature

Date: ______________________

By: ______________________________
Patient or Patient's Representative Signature

By: ______________________________
Print Patient's Name

Date: ______________________________

____
Print or Stamp Name of Physician, Medical Group or Association