California Institute of Cosmetic & Reconstructive Surgery
VIPUL R. DEV, M.D./ NARAYANAN M. NAIR, M.D.
REGISTRATION FORM

Insurance patients: Please fill out the entire first page of this registration form (2nd page is for patients seeking Cosmetic treatment).
Cosmetic patients: Please indicate "Cash Pay." Insurance information is preferred but optional. Please complete 2nd page of this form.

Date: **Primary Care Physician:**

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Ethnicity:	Birth date:	Age:	Sex: ☐ M ☐ F

Mailing address:	City:	State:	ZIP Code:

Cell Phone no.: ( )	Home Phone no.: ( )		Social Security No.:

Occupation:	Employer:	Employer phone No.: ( )

Chose CICRS because/referred to clinic by (Please check one box): ☐ Dr. ☐ Insurance plan ☐Hospital
☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Email Address:	Language Preference:

INSURANCE INFORMATION

(Please give your insurance card and co-payment to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ PPO ☐ HMO ☐ MEDICARE ☐ CASH PAY ☐ OTHER

Subscriber's name:	Subscriber's S.S. No.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature: **Date:**

CALIFORNIA INSTITUTE OF COSMETIC & RECONSTRUCTIVE SURGERY

VIPUL R. DEV M.D. & NARAYANAN NAIR M.D.

COSMETIC REGISTRATION PORTION

(If you provided Name/DOB/Phone Numbers/Address on the first page these identifiers are optional on this page.)

PATIENT NAME:				☐ M ☐ F
	Last Name	First Name	M.I.	SEX

DOB (MM/DD/YYYY)	AGE	ETHNICITY	CELL PHONE	HOME PHONE

STREET ADDRESS	CITY	STATE	ZIP

REFERRED BY:

☐ SELF ☐ FAMILY/FRIEND ____________ ☐ DR. ____________

☐ OTHER: ____________

HOW DID YOU HEAR ABOUT US?

☐ TV ____________ ☐ INTERNET ____________ ☐ RADIO ____________

☐ FAMILY/FRIEND ____________ ☐ DOCTOR ____________

☐ SOCIAL MEDIA (INSTAGRAM/FACEBOOK/OTHER): ____________

☐ OTHER: ____________

WHAT IS THE REASON FOR YOUR VISIT TODAY?

☐ CONSULTATION ☐ PRICE QUOTE(S) ☐ TREATMENT/PROCEDURE(S)

☐ OTHER ____________

SERVICES YOU ARE INTERESTED IN:

☐ PLASTIC/RECONSTRUCTIVE SURGERY:

☐ BOTOX ☐ FILLERS ☐ SKIN CARE TREATMENTS ☐ SKIN CARE PRODUCTS

☐ WEIGHT LOSS ☐ OTHER ____________

The above information is true to the best of my knowledge:

Patient Signature: ____________ Date: ____________

California Institute of Cosmetic & Reconstructive Surgery
Vipul R. Dev, M.D., Narayanan M. Nair, M.D.
Health Questionnaire

Patient Name: ____Date: _________________________

The following questions regarding your health have been carefully selected as pertinent to your care. Please answer to the best of your ability.

Referring Physician: _____________________________ Reason for Visit: ____________________________________

Is there a History of this problem? ☐ No ☐ Yes ____

Is this a surgical problem? ☐ No ☐ Yes ____

Are you in pain? ☐ No ☐ Yes If yes, what makes the pain worse? ____

How long have you had this problem? ____

HAVE YOU EVER BEEN DIAGNOSED FOR:

❑ High Blood Pressure ❑ Tuberculosis ❑ Coronary Disease ❑ Rheumatic Fever ❑ Diabetes ❑Valley Fever

❑Hepatitis A ❑Hepatitis B ❑Hepatitis C ❑ Emphysema

Do you have any reason to believe you may have been exposed to the HIV virus (AIDS) (i.e. blood transfusion, drug use, lifestyle, etc.)
❑Yes ❑No

MEDICATIONS:

Have you ever taken medications for your heart? ❑Yes ❑No
Have you ever had a general anesthetic? ❑Yes ❑No If yes, when? __________________________________
And did you have any problems? ❑Yes ❑No If yes, explain ________________________________

Are you ALLERGIC to any medications or hospital products, including: tape, iodine, latex, etc.?
❑Yes ❑No **If yes, please list what meds. and include what reactions you have?**

____

LIST ALL MEDICATIONS YOU HAVE TAKEN WITHIN THE PAST TWO WEEKS. Include Vitamins, Oral Contraceptives, Supplements, Eye Drops, Skin Ointments, Cold Tablets, Headache Meds. If you are no longer taking the medications, list when you stopped**.**

If NONE, check here ❑

Medications	Reason for Taking	Dosage & Frequency

PERSONAL HISTORY:

Age: ______________________ Height: ___________________ Current Weight: ____________________________________

What is the most you have ever weighed? ___________________ Your weight one year ago? ____________________________

When was your last Chest X-Ray? Date: ___________________ Location: ____

When was your last EKG? Date: __________________________ Location: ____

Have you ever had a Blood Transfusion? ❑Yes ❑No

PREVIOUS COSMETIC SURGERIES/PROCEDURES:

❑Yes ❑No

Please Check all that Apply & Date of Surgery:

❑Breast Augmentation: ❑Silicone ❑Saline Date(s): ___________________

❑Breast Reduction Date:______________________________ ❑Breast Lift Date: _________________________________

❑Breast Revision Date: ______________ ❑ Other Breast Surgery:______________________ Date:___________________

❑Liposuction What areas? ____ Date: __________________

❑Tummy Tuck Date: __________________ ❑Butt Augmentation Date: ____

❑Arm Lift Date: _____________________ ❑Thigh Lift Date: ____

❑Body Lift Date: _____________________ ❑Upper or Lower Eyelid Lift Date: __________________________________

❑Facelift Date: ______________________ ❑Rhinoplasty (Nose Reshaping) Date: _________________________________

❑Facial Implants Where/What: _____________________________ Date: ____

❑Brow Lift Date: _____________________________________ ❑Neck Lift Date: _____________________________________

❑Ear Reshaping Date: ________________ ❑Scar Revision to Where? _______________________ Date: _____________

❑Other Cosmetic/Plastic Surgeries: ____ Date: _____________

NON Surgical Treatments

❑ Botox Last Treatment Date: __________________________ ❑Thread Lift Date: __________________________________

❑Dermal Fillers (Juvederm, Restyling, etc.): ____ Date: _________________

❑Fat Injections Where? ________________ Date___________________ ❑Chemical Peel Date: __________________

❑Any Laser Treatments Where? ___________________________________ Date of Last Treatment: _____________________

❑Microdermabrasion Date: ___________________________ ❑Dermabrasion Date: __________________________________

❑Other: ____ Date: __________________

PAST SURGERIES: Please list all surgeries you have ever had. **If NONE, check here** ❑

Surgery	Year	Facility, Surgeon/Dr.

PHYSICAL HABITS:

Can you run up a flight of stairs? ❑Yes ❑No

Can you walk up a flight of stairs? ❑Yes ❑No

How far can you walk? ____

Are you physically active? (this includes any house work, yard work etc.) ❑Yes ❑No

SOCIAL HISTORY:

Do you drink alcohol? ❑Yes ❑No If yes, how often? ______________________________

Smoking: ❑ Never Smoked ❑ Currently Smoking (_______ packs per day) ❑ Quit Smoking (_________yrs./mon ago)
❑ Socially ❑ Nicotine Patch

Do you use street drugs? ❑Yes ❑No
If yes, what? How often? How Recent? ______________________________

FEMALE HISTORY:

When was your last Mammogram? Date: __________________ Location: ______________________________

Are you pregnant? ❑Yes ❑No If yes, number of months: ______________________________

Number of pregnancies: ______________ Births _______________ Other Important Info: ______________________________

Date of last menstrual period/or onset of menopause______________________________

Personal History of Breast Cancer? ❑ Yes ❑ No If yes, date(s) diagnosed? ______________________________

Family History of Breast Cancer? ❑ Yes ❑ No If yes, who & age at diagnosis: Mother______________________________

Sister(s)__________________________ Aunt(s)____________________________ Grandmother(s)______________________

SKIN HISTORY:

Have you ever seen a Dermatologist for your skin? ❑Yes ❑No If yes, for what? ______________________________

Do you currently, or have you ever used any topical medications on your skin? (this includes any Salicylic, Glycolic, Lactic Acids or Retin A products)

❑Yes ❑No If yes, what meds.? ______________________________

If you have in the past when did you stop usage? ______________________________

Have you ever used Accutane? ❑Yes ❑No If yes, when was the last dose? ______________________________

Do you form thick or raised scars? ❑Yes ❑No

SYSTEMS REVIEW:

Please circle the following disease or symptoms you have or have had in the past. If yes, briefly explain.

General (Recent Appetite Change, Fatigue, Weakness, Fever, Unusual Sleeping Habits)

❑None If yes, ______________________________

Skin (Rashes, Sores, Bruising, Hair Loss, Itching, Lesions, Keloid Scars, Hives, Acne, Night Sweats, Skin Disease)

❑ None If yes, ______________________________

Hearing, Eyes, Nose, Throat (Migraines, Hearing Changes, Nose Bleeds, Sore Throat, Hoarseness, Sinus Problems)

❑ None If yes, ______________________________

Do you wear Eye Glasses or Contact Lenses? ❑Yes ❑No

Breasts (Pain, Discharge, Enlargement, Lumps)

❑None If yes, ______________________________

Respiratory (Pneumonia, Emphysema, Chest Pain, Shortness of Breath, Cough, COPD)

❑None If yes, ______________________________

Cardiovascular (Heart Disease, Angina, Palpitations, Stroke, Arrhythmias, Hypertension, Murmur, CAD)

❑None If yes, ______________________________

Gastrointestinal (Nausea, Vomiting, Jaundice, Diarrhea, Constipation, Indigestion, Bloody Stools, Abdominal Pain, Liver Disease, Cirrhosis, Gallbladder Disease, Colitis/Bowel Disease)

❑None If yes, ______________________________

Genitourinary (Bloody Urine, Pain on Urination, Stones, Urinary Infections, Increased Urinary Frequency)

❑None If yes, ____

OB/GYN (Pain on Menstruation, Discharge, Infection, Intermenstrual Bleeding, Menopause)

❑None If yes, ____

Musculoskeletal (Arthritis, Fractures, Dislocations, Weakness, Varicose Veins, Back Problems, Swelling of Hands & Feet)

❑None If yes, ____

Neurologic (Vertigo, Headaches/Migraines, Syncope, Seizures, Paralysis, Loss of Memory, Stroke, Numbness, Polio, Meningitis, Dizziness, Convulsions or Epilepsy, Neuritis)

❑None If yes, ____

Hematologic (Excessive Bleeding, Easy Bruising, Swollen Lymph Nodes, Recurrent Infections, Hay Fever, Anemia)

❑None If yes, ____

Endocrine (Thyroid Disease, Obesity, Gynecomastia, Hot/Cold Intolerance, Nervousness)

❑None If yes, ____

Psychiatric (Depression, Anxiety, Suicide Ideation, Hallucinations)

❑None If yes, ____

Do you have or ever had any **Cancer(s)**? ❑Yes ❑No If yes, what type(s)? ______________________

Have you ever had a Head Injury or a Concussion? ❑Yes ❑No If yes, ______________________

FAMILY HISTORY:			
FAMILY MEMBER	**AGE**	**ALIVE/DECEASED**	**MEDICAL CONDITIONS**
MOTHER			
FATHER			
SISTER (S)			
BROTHER (S)			

Preferred Pharmacy:

Name:

____

Phone:

____

Address/Location:

____

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any of his staff members responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: ______________________ **Date:** ______________________