MICHAEL A. PERSKY, M.D. F.A.C.S.
FACIAL PLASTIC SURGERY
PATIENT INFORMATION

Last Name | First Name | Middle | Social Security#

/ / | F M | M - S - W - D - DP

Birth Date | Age | Gender | Driver's License # | Marital Status

Address | City | State | Zip

Preferred method of Contact | Ok to leave message? | Ok to leave w/someone else?

( ) CELL ( ) _____ YES NO YES NO

( ) HOME ( ) _____ YES NO YES NO

( ) WORK ( ) _____ YES NO YES NO

Ok for Appt Reminder | Ok for office PROMO

( ) EMAIL _____ @ _____ YES NO YES NO

Referred by: _____ May we thank them? Yes No

Doctor___ Family___ Friend___ Website___ Yelp___ Magazine___ Realself___ Social Media___

Employer | Employer Phone # | Occupation

Name of Primary Physician | Physician Phone #

IN CASE OF EMERGENCY:

Name | Phone | Relationship

It is our office policy that all patients have their photo taken for their medical chart. This picture is strictly for the patient's file ONLY and is unrelated to our photography consent form. The above information is true to the best of my knowledge.

I understand that Dr. Persky is not contracted with Medicare or any other insurance carriers.

I understand that I am financially responsible for all services rendered. No refunds will be issued on any services rendered.

Patient / Guardian Signature **Date**

MICHAEL A. PERSKY, M.D., F.A.C.S. FACIAL PLASTIC SURGERY

PATIENT MEDICAL HISTORY

Patient Name: _____ **Height:** _____ **Weight:** _____ **Age:** _____

List Current Medications (including over the counter/vitamins/supplements etc) :

_____

_____

Are you allergic or have had a reaction to the following:

Aspirin/Ibuprofen/Tylenol	( ) No	( ) Yes
Latex or Metals	( ) No	( ) Yes
Codeine/Vicodin/any sedatives	( ) No	( ) Yes
Penicillin/Antibiotics	( ) No	( ) Yes

If YES, please specify: _____

Other: _____

History of ANY cosmetic/medical surgeries: **Date:**

_____ _____

_____ _____

_____ _____

_____ _____

Do you have or had any reaction to anesthesia?

If so, to which?	Local	( ) No	( ) Yes
	General	( ) No	( ) Yes
	Topical	( ) No	( ) Yes
Family history?		( ) No	( ) Yes
Do you have facial implants?		( ) No	( ) Yes

Where? _____

Have you ever had any of the following?

Botox Xeomin Dysport Laser

Radiesse HA Filler Silicone Bellafill

Sculptra Peels Voluma _____

Last injections date: _____

Social History

Smoking	( ) No	( ) Former - Date of quitting	_____	( ) Yes - Packs/Day _____
Alcohol	( ) No	( ) Occasional/drinks per week	_____	( ) Recovering
Tanning beds	( ) No	( ) Yes, how often	_____	
Exercise	( ) No	( ) Yes, how often	_____	
Recreational drugs	( ) No	( ) Yes, please specify	_____	

Check YES or NO to indicate whether or not you have had or now have the following conditions or treatments

Heart Attack	( ) No	( ) Yes	Heart Conditions	( ) No	( ) Yes
Stress Incontinence	( ) No	( ) Yes	Keloids	( ) No	( ) Yes
Mitral Valve	( ) No	( ) Yes	Lupus	( ) No	( ) Yes
Artificial Heart Valve	( ) No	( ) Yes	Emphysema	( ) No	( ) Yes
Chest Pain (Angina)	( ) No	( ) Yes	**Bruxism (teeth clinching)/TMJ**	( ) No	( ) Yes
Congenital Heart disease	( ) No	( ) Yes	Shortness of Breath	( ) No	( ) Yes
Stroke	( ) No	( ) Yes	Hay Fever	( ) No	( ) Yes
High/Low Blood Pressure	( ) No	( ) Yes	Sinusitis	( ) No	( ) Yes
Hepatitis C/HIV *(optional)*	( ) No	( ) Yes	**Cold Sore (EVER)**	( ) No	( ) Yes
Rheumatic Fever	( ) No	( ) Yes	Ulcers	( ) No	( ) Yes
Urinary Frequency	( ) No	( ) Yes	Migraines	( ) No	( ) Yes
Kidney Problems	( ) No	( ) Yes	**Metal Implants**	( ) No	( ) Yes
Liver Disease	( ) No	( ) Yes	Anxiety	( ) No	( ) Yes
Tuberculosis/or symptoms of	( ) No	( ) Yes	Diabetes	( ) No	( ) Yes
Hepatitis B	( ) No	( ) Yes	**Chronic respiratory diseases**	( ) No	( ) Yes
Depression	( ) No	( ) Yes	*post nasal drip/GERD/COPD/asthma/emphysema*		
Aerosol transmissible diseases	( ) No	( ) Yes	Cancer - **ANY**	( ) No	( ) Yes

Flu/Pertussis/Measles/Mumps/Rubella/Chicken Pox/Meningitis/MRSA

Type: _____

If yes, specify: _____ Date: _____

Any other medical conditions: _____ _____

If an employee(s) should be exposed to bloodborn pathogen, you are consenting to oblige to our protocol following such event

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

Signature: _____ **Date:** _____

MICHAEL A. PERSKY MD, FACS
FACIAL PLASTIC SURGERY

16311 VENTURA BLVD. SUITE 600
ENCINO, CA 91436
(818) 501-3223

COSMETIC INTEREST QUESTIONNAIRE

Thank you for scheduling your consultation with Dr. Michael Persky

In an effort to better serve your aesthetic goals, please take a few minutes to fill out this form

PATIENT NAME: _____ Date: _____

WHAT IS THE REASON FOR YOUR VISIT TODAY?

Fine Lines ___ Deep Wrinkles ___ Dark Circles ___ Puffiness ___ Hollowness ___ Acne ___

Nasolabial Folds ___ Loose Jowls ___ Loose Neck ___ Loss Facial Volume ___ Redness ___

Sun Damaged Skin ___ Body Contouring ___ Body Skin Tightening ___ Baggy Eye Lids ___

Thin Lips ___ Skincare ___ Snoring ___ Scar ___ Cheeks ___ Breathing Problems ___ Nose ___

Bruxism (teeth clinching) and/or TMJ (Temporomandibular Joint Dysfunction ____

Stress induced incontinence____ Urinary Frequency____

Are you interested in surgical procedures? _____or non-surgical Procedures? _____

Plastic Surgery, please specify: _____

Additional comments you would like to share with us:

_____

_____

_____

_____

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PHOTOGRAPHY – VIDEO CONSENT

I permit Dr. Michael A. Persky to photograph/video tape me under the following conditions:

1. The photographs/videos may be taken only with the consent of Dr. Persky.
2. The photographs/videos will be taken by Dr. Persky or someone chosen by him.

In addition to the photographs/videos taken for your medical record that you are consenting to on "Patient Information" form, the photographs/videos may also be used for these following purposes:

PLEASE INITIAL EACH ONE THAT APPLIES:

_____ Shown anonymously to other patients
_____ Furthering medical research, education or science
_____ Publication in professional journals or textbooks
_____ Website, Social Media Platforms & Marketing
_____ Decline

I understand that any publication of my pictures shall not identify me by name.

CANCELLATION POLICY

- SURGICAL APPOINTMENT: We require 5 days' notice for cancelling any surgery whether in-patient or out-patient procedure. You will not be refunded if failure to notify our office 5 days prior to your surgery.
- NON-SURGICAL DEVICE PROCEDURE APPOINTMENT: We require 5 days' notice for cancelling your appointment. Your deposit will not be refunded if failure to notify our office 5 days prior to your appointment such as, included but not limited to, Ulthera, Profound & Fraxel Laser.
- INJECTABLE/FOLLOW-UP/CONSULTATION APPOINTMENT: We require 48 hours' notice for cancelling your appointment. Failure to notify our office may result in a $50 late cancellation fee.
- LAST MINUTE CANCELLATIONS AND NO-SHOWS: The office may take a reservation fee of $50 upon booking your next visit that will be applied towards your treatment.

Please note that we do not issue refunds on services/treatments rendered and that there are no guarantees since individuals results will/may vary. We will only issue a refund on retail items if the merchandise you purchased is defective within 30 days. Thank you.

Patient's name_____

Patient's signature_____Date____/____/_____

<u>If patient is a minor or is unable to consent</u>:

Parent/Guardian's name_____

Parent/Guardian's signature_____Date____/____/_____

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Dear Patient:

Physicians have always protected the confidentiality of health information by sealing medical records. State and federal laws also attempt to ensure the confidentiality of this sensitive information.
The federal government publishes regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health care providers and health plans.

This regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your physician, the hospital, or other health care provider will need to consider the privacy rule. All health information including paper records, oral communications, and electronic formats (such as email) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. We also take precautions in our office to safeguard your health information such as training our employees and employing computer security measures. Please feel free to ask your physician or our privacy officer about exercising your rights or how your health information is protected in our office.

You may ask to read **The Notice of Private Practices** which explains our privacy practices. It contains very important information about how your confidential health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information.

Please let us know if you have any questions about our Notice of Privacy Practices. You may contact our Privacy Officer at (818) 501-3223, or discuss any questions you may have with your physician.

Signature:_____ Date:_____

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CREDIT CARD AUTHORIZATION

I, _____, authorize Michael A. Persky MD, A Medical Corporation to charge my credit card in the amount of $ 50 if I shall no-show or cancel last minute for the consultation appointment.

This will be a one-time charge that may be applied towards services upon rescheduling. I agree to pay the above total according to card issuer agreement.

_____
Patient Name

_____ _____
Card Holder Name Card Holder Signature & Date

Credit Card # _____ CVV code _____

Expiration Date _____

Card Billing Address _____

Date of Authorization _____

Special Notes/Instructions: