GANCHI PLASTIC SURGERY

Princeton ~ Harvard ~ Duke

Welcome to our office. We are committed to providing you the best care possible. Your total comfort is our priority. Please assist us by providing the following information. All information is kept strictly confidential.

First Name ____ M.I. ____ Last Name ____ Nickname ____ Date ____

E-mail Address ____ Social Security No. ____-____-____ Birth Date ____ Age ____ Male☐ Female☐

Address - Street ____ City ____ State ____ Zip ____ No Mail ☐ Mail OK ☐

Home Phone - prefer☐ ____ Cell Phone - prefer☐ ____ Cell Phone Company ____ Work Phone - prefer☐ ____

OK to email appointment information? ☐ Yes ☐ No
OK to email medical information? ☐ Yes ☐ No
OK to email events/specials? ☐ Yes ☐ No

OK to text appointment information? ☐ Yes ☐ No
OK to text medical information? ☐ Yes ☐ No
OK to text events/specials? ☐ Yes ☐ No

*** Note – We need the name of your cell phone company in order to be able to text you.**

Your Occupation ____

Employer Name / Street Address ____ City ____ State ____ Zip ____

Marital Status ____ Spouse's Name ____ Spouse's Occupation ____ Spouse's Phone No. ____

Number of Children ____ Children's Ages ____

Emergency Contact ____ Relationship ____ Cell Phone ____ Work Phone ____

Relatives who are patients in our office and relationship: ____

Please let us know how you found out about us. Be as specific as possible. Check all that apply.

☐Friend/Family – ____ (Name) May we acknowledge the referral? ☐Yes ☐ No

☐ Internet – What site (Please be specific)?
- ☐ ASPS/ASAPS
- ☐ Care Credit
- ☐ Implant Info
- ☐ Natrelle.com
- ☐ Vitals
- ☐ Yahoo
- ☐ Cosmetic Surgery.com
- ☐ NJ Soc Plastic Surgery
- ☐ Real Self.com
- ☐ Castle Connolly
- ☐ Bing
- ☐ Google
- ☐ Other Internet: ____
  - ☐ Searched For: ____

☐ Physician – Name: ____

☐ Publication: ____

The web is becoming a key way patients learn about our practice. Do you participate in any of the following (check all that apply):

- ☐ Yelp
- ☐ RealSelf
- ☐ Google Reviews
- ☐ Facebook
- ☐ Angie's List
- ☐ Twitter

☐ Blogging: if yes, what blog: ____

What website(s) do you find helpful in researching our practice or a procedure?

____

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Name ____________ Birth Date ________ Age ______ Date ____________

Reason for Visit (check all that apply):

- ☐ Arm Lift
- ☐ Body Lift
- ☐ Botox / Dysport
- ☐ Breast Augmentation (Saline, Silicone)
- ☐ Breast Lift
- ☐ Breast Reduction (Women, Men)
- ☐ Buttock Enhancement (Fat Injection)
- ☐ Calf Implants
- ☐ Chin Implant
- ☐ Ear Surgery (Otoplasty)
- ☐ Excessive Sweating (Botox, PrecisionTX)
- ☐ Eyelid Surgery
- ☐ Face Lift
- ☐ Fat Injection (Face, Body, Breasts, Hands)
- ☐ Fillers (Restylane, Juvederm, Voluma, etc.)
- ☐ Forehead / Brow Lift
- ☐ Ganchi Skin Care Products
- ☐ Gynecomastia (Male Breast Reduction)
- ☐ Hair Removal (IPL)
- ☐ Hair Transplantation/Restoration (NeoGraft)
- ☐ Hand Rejuvenation
- ☐ Inverted Nipple Correction
- ☐ Labiaplasty - Inner / Outer
- ☐ Latisse for Eyelashes
- ☐ Laser Rejuvenation
- ☐ Lip Enhancement
- ☐ Liposuction / SmartLipo
- ☐ Microdermabrasion
- ☐ Neck Lift / Shaping / PrecisionTX
- ☐ Nipple Reduction / Enlargement
- ☐ "Non-Surgical" Facial Rejuvenation
- ☐ Rhinoplasty (Nose Surgery)
- ☐ Scar Treatment / Correction
- ☐ Skin Care / Peels / Photofacial
- ☐ Spider Vein Removal (Face Only)
- ☐ Surgery after Pregnancy
- ☐ Surgery after Weight Loss
- ☐ Tummy Tuck (Abdominoplasty)

☐ Other: ______________________________

Have you seen other plastic surgeons? ☐Yes ☐No

If yes, who have you seen? ______________ ______________

Primary Physician: ______________________ Phone: ______________

Your Pharmacy: ______________________ Phone: ______________

When was your last physical examination? ______________ Was everything OK? ☐Yes ☐No

Are you in good health? ☐Yes ☐No Explain: ______________________

Have you used prescription pain medication in the past year? ☐Yes ☐No If yes, when? ____________

List all drug allergies and your reaction: ______________________________

List other allergies (latex, tape, food, seasonal): ______________________________

Family History – Have any of your blood **relatives** had the following problems:

Yes	No	
☐	☐	Abnormal Bleeding
☐	☐	Abnormal Clotting / Phlebitis
☐	☐	Anesthesia Problems
☐	☐	Cancer
☐	☐	Diabetes
☐	☐	Heart Disease
☐	☐	Lung Disease
☐	☐	Mental Illness
☐	☐	Stroke
☐	☐	Suicide

If yes to any of the above, please give details: ______________________________

____

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Have **you** ever had or do **you** now have:

Name ____

Yes No Eyes
- ☐ ☐ Wear Glasses / Contacts
- ☐ ☐ Cornea Problems / Cataracts
- ☐ ☐ Poor Vision / Loss of Vision
- ☐ ☐ Eye or Eyelid Surgery (list below)
- ☐ ☐ Blurred Vision
- ☐ ☐ Dry Eyes
- ☐ ☐ Crossed or Lazy Eyes
- ☐ ☐ Glaucoma

Nose
- ☐ ☐ Injury to Nose
- ☐ ☐ Nasal Allergies
- ☐ ☐ Nose or Sinus Surgery (list below)
- ☐ ☐ Difficulty Breathing through Nose
- ☐ ☐ Nose Bleeds

Heart
- ☐ ☐ Chest Pain / Angina
- ☐ ☐ Heart Attack
- ☐ ☐ Irregular Heart Beat
- ☐ ☐ Heart Murmurs
- ☐ ☐ Pacemaker / Defibrillator
- ☐ ☐ **Mitral Valve Prolapse**
- ☐ ☐ **High Blood Pressure**
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Poor Circulation
- ☐ ☐ Heart Disease

Chest
- ☐ ☐ Bronchitis / Chronic Cough (circle)
- ☐ ☐ Sleep Apnea / Snoring (circle)
- ☐ ☐ Shortness of Breath
- ☐ ☐ **Asthma / Wheezing** (circle)
- ☐ ☐ Emphysema

Breast
- ☐ ☐ Nipple Discharge
- ☐ ☐ Breast Lump / Biopsy (Result ___________________)
- ☐ ☐ Breast Pain
- ☐ ☐ Mammogram (Result _____________ Date _________)
- ☐ ☐ Did You Breastfeed?

Psychiatric
- ☐ ☐ Psychiatric Care (Diagnosis _____________________)
- ☐ ☐ Drug or Narcotic Dependency
- ☐ ☐ Alcoholism
- ☐ ☐ Depression / Anxiety
- ☐ ☐ Suicide Attempt
- ☐ ☐ Body Dysmorphic Disorder
- ☐ ☐ Anorexia / Bulimia (circle)

Yes No Face
- ☐ ☐ Facial Cosmetic Surgery (list below)
- ☐ ☐ Facial Paralysis / Weakness / Bells Palsy
- ☐ ☐ Use Retin-A / Accutane (circle)
- ☐ ☐ Chemical Peels, Dermabrasion (circle)
- ☐ ☐ Laser Resurfacing
- ☐ ☐ Cold Sores / Fever Blisters

Other
- ☐ ☐ Bad Scarring / Keloids
- ☐ ☐ Use Birth Control (Type ______________________)
- ☐ ☐ Abnormal Bleeding
- ☐ ☐ Bruise Easily
- ☐ ☐ Abnormal Clotting / Phlebitis
- ☐ ☐ Anemia / Low Blood Count
- ☐ ☐ Blood Disease
- ☐ ☐ Slow or Poor Healing
- ☐ ☐ Varicose Veins
- ☐ ☐ Swelling of Ankles
- ☐ ☐ Blood Transfusion (When _____________________)
- ☐ ☐ Acid Reflux / Heartburn
- ☐ ☐ Stomach Ulcers
- ☐ ☐ Digestive Problems
- ☐ ☐ **Diabetes** (Taking Insulin? ☐Yes ☐No)
- ☐ ☐ Neck / Back / Spine Problems
- ☐ ☐ Muscle / Joint / Bone Pain
- ☐ ☐ Arthritis (Where ______________________________)
- ☐ ☐ HIV / AIDS
- ☐ ☐ Steroid / Cortisone Use (When ________________)
- ☐ ☐ Thyroid Problems
- ☐ ☐ Autoimmune Disease (Which __________________)
- ☐ ☐ Dentures
- ☐ ☐ Hepatitis
- ☐ ☐ Neurological Disorder (Which _________________)
- ☐ ☐ Migraines / Headaches (circle)
- ☐ ☐ Stroke / TIA
- ☐ ☐ Epilepsy / Convulsions
- ☐ ☐ Fainting / Dizziness
- ☐ ☐ Numbness (Where ____________________________)
- ☐ ☐ Kidney Disease
- ☐ ☐ Staph Infection
- ☐ ☐ Frequent Skin Infections / Boils
- ☐ ☐ Tuberculosis
- ☐ ☐ Yeast Infections
- ☐ ☐ Weight Change (How Much ___________________)
- ☐ ☐ Herpes (Genital or Shingles)
- ☐ ☐ Painful Intercourse
- ☐ ☐ Cancer (Of ___________________________________)
- ☐ ☐ Skin Cancer
- ☐ ☐ Hernia (Where _______________________________)
- ☐ ☐ Go Tanning Outside / Use Tanning Beds (circle)

If **yes** to any of the above, **please give details**: ____

____

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Name ______ Birth Date ______ Age ______ Height ______ Weight ______

List all medications you are taking (including birth control, water pills, sleep pills, aspirin products, blood thinners, over-the-counter pills, steroids, cortisone, heart or blood pressure pills, hormones, pain medication, supplements, and herbal medication): ______

______

List all other past and current medical conditions and illnesses: ______

______

List all operations (including cosmetic) with dates and name of surgeon: ______

______

Have you ever had a bad surgical result? ______

Have you ever had a bad reaction to anesthesia? ______

List all hospitalizations, injuries, and accidents with dates: ______

______

Have you ever consulted a professional for emotional problems? Explain: ______

Do you smoke or have you ever smoked? ☐Yes ☐No ☐I Quit If so, how much? ______

Are you exposed to second hand cigarette, cigar or pipe smoke? ☐Yes ☐No Explain: ______

Do you use nicotine products or electronic cigarettes? ☐Yes ☐No If so, what do you use? ______

Do you drink alcohol? ☐Yes ☐No ☐I Quit If so, how many drinks per week? ______

Do you use or have you ever used drugs? ☐Yes ☐No ☐I Quit Explain: ______

Are you pregnant or planning a pregnancy? ☐Yes ☐No You last menstrual period: ______

Before you undergo surgery, list any other facts (medical or other) that we should know about you: ______

______

List below people with whom we are authorized to discuss your medical information:

Name	Relationship	DOB	Name	Relationship	DOB
Name	Relationship	DOB	Name	Relationship	DOB

- I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the above have been answered to my satisfaction. I will not hold my surgeon, or any of his/her staff responsible for any errors or omissions that I have made in completing the above questionnaire.
- I am responsible for and will pay all charges and fees of Ganchi Plastic Surgery for services rendered to me and/or my child. I understand that although I may have insurance to cover the cost of treatment, I remain responsible for payment. All payments are due at the time services are rendered.
- I was offered/received the Ganchi Plastic Surgery Notice of Privacy Practices.

Signature ______ ☐Guardian/Parent Date ______

Ganchi Plastic Surgery, PA and Ganchi Plastic Surgery Center are operated by Parham A. Ganchi, PhD, MD

I have reviewed the above information with the patient:

_G A N C H I   P L A S T I C   S U R G E R Y_
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PATIENT INFORMATION

Welcome to our Center! We are delighted that you have chosen our facility and will try our best to make this a pleasant and comfortable experience for you.

Please take a few minutes to complete the registration form and return it to our receptionist. We ask that you read and sign our Patient Information statement so that you fully understand our financial policies.

Payment is required at the time of service. There is a fee for all consultations. Cancellations with less than 48 hours notice will incur a $80 rescheduling fee. Appointments that have not been confirmed within 48 hours of the appointment will be cancelled and offered to patients on our waitlist. There is no charge for postoperative visits for up to one year after cosmetic surgery.

Please be aware that we do not participate with any insurance plans. We do not accept insurance as payment in full. You are responsible for any charges incurred and will be billed for any balance including co-payments, non-covered charges, deductibles, and any balance beyond that paid by your insurance. There is a $50 per form administrative fee for completing disability/time off related paperwork.

A 10% non-refundable deposit is required to hold a date for a cosmetic procedure. The balance is due 3 weeks prior to the procedure date and is non-refundable at that time.

If laboratory tests and/or medical clearances are required, the charges are not determined by our Center and will be billed to you by the independent provider of these services.

We strive to provide excellent care to each of our patients and hold ourselves to the nationally recognized standards of the Joint Commission on Accreditation for Healthcare Organizations (JCAHO). As such, we are always looking for ways to improve. We would welcome any suggestions or ideas that you feel would enhance your experience with us. Feel free to contact Leyla Sarram, our office manager, or any of our staff to make a suggestion or to get further information on our complaint resolution policy. You may also contact JCAHO at 800.994.6610.

We look forward to meeting you and being of service to you. Please do not hesitate to ask any of our staff for assistance or if you have any questions regarding this form. We appreciate your trust and promise to bring you the latest in medical techniques with a personal touch.

I have read the above information and agree to the terms outlined. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private and/or auto insurance, and any other health plans to Ganchi Plastic Surgery. A photocopy of this assignment is to be considered as valid as an original. I authorize the use of my signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. This assignment will remain in effect until revoked by me in writing. I am ultimately responsible for all professional fees.

____ ________________________

Print Name   Date of Birth

____ ________________________

Signature of patient or guardian   Date

G A N C H I   P L A S T I C   S U R G E R Y
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PATIENTS' RIGHTS AND RESPONSIBILITIES

YOU HAVE CERTAIN RIGHTS

1. You have the right to be treated with respect, consideration and dignity.
2. You have the right to high-quality medical care delivered in a safe, timely, efficient and cost-effective manner and the right to be assured that the expected results can be reasonably anticipated.
3. You have the right to privacy to the extent possible.
4. You have the right to have your disclosures and records treated confidentially and, except when required by law, those disclosures and records will not be released without your approval.
5. You have the right to be provided, to the degree known, complete information concerning your diagnosis, evaluation, treatment and prognosis.
6. You have the right to copies of your medical records at a nominal cost and, if you request it, those records will be transferred to another practitioner in a timely manner.
7. You have the right to be informed of all reasonable options or alternatives for care and/or treatment and of the potential advantages and disadvantages of each including the advantages or disadvantages and the alternatives to having the procedure performed in an office or other out-patient facility.
8. You have the right to participate in decisions regarding all aspects of care.
9. No procedure or treatment will be undertaken without your informed consent after the alternatives mentioned in #7, above have been discussed with you.
10. You have the right to refuse any diagnostic procedure or treatment and to be advised of the likely medical consequences of such refusal.
11. You have the right to know all your rights as outlined above.
12. You have the right to know the conduct expected of you in the facility and the consequences of failure to comply with these expectations.
13. You have the right to know the services available at the facility.
14. You have the right to know the provisions for after-hours and emergency care.
15. You have the right to know if any of the planned procedures or treatments is part of a research study and the right to refuse to participate in that study.
16. You have the right to know whether or not your providers are insured.
17. You have the right to know how to go about expressing suggestions to the facility and the policies regarding grievance procedures and external appeals if you are dissatisfied with your treatment.
18. You have the right to know the name of your provider.
19. You have the right to know what fees are expected and what the payment policies are.
20. You have the right to know what your provider's credentials are.
21. You have the right to change providers.

YOU ALSO HAVE CERTAIN RESPONSIBILITIES

1. You have the responsibility to accurately and completely provide all clinical personnel with the health information they need including any medications you are taking. All forms should be filled out completely and accurately.
2. You have the responsibility to follow directions of the staff or physician regarding diet and/or medication.
3. You have the responsibility to abstain from using any drugs that have not been prescribed for you and that you have not revealed to your staff or physician. Abstain from the use of alcohol as directed by your physician.
4. You have the responsibility to follow all instructions given to you after any procedure(s) and to prioritize and be on time for all follow-up appointments.
5. You have the responsibility to inform the staff or physician if you do not understand any directions or you do not understand the course of treatment planned for you.
6. You have the responsibility to inform the staff or physician if you are unable to comply with your post-procedure instructions <u>BEFORE</u> you have the procedure.
7. You have the responsibility to timely pay all medical bills which are not in dispute and to forward to us any monies you receive from any insurance company for our services.

______________________________	____________________
Print Name	Date
______________________________	____________________
Signature	Date of Birth