

West Coast Plastic Surgery Center, Inc.
 Yuly Gorodisky, D.O.
 Plastic and Reconstructive Surgeon
 1250 La Venta Drive, St 100
 Westlake Village, CA 91361
 (805) 728-1749

Today's Date: _____

Patient's Name: _____ Date of Birth: _____
 Age: _____ E-mail address: _____
 Home Address: _____
 City _____ State _____ Zip _____
 Social Security #: _____
 Home Phone#: _____ Cell Phone#: _____
 Occupation: _____ Employer: _____
 Marital Status: _____
 Spouse Name: _____
 Spouse Occupation: _____ Spouse Phone #: _____
 Family Physician/Internist: _____ Phone # _____
 Address: _____
 How did you hear about our practice? _____

Emergency Contact:

Name: _____ Relationship: _____
 Home Phone: _____ Work/Cell Phone: _____

Purpose of Today's Visit:

Please specify in your own words: _____

Please circle the procedure(s) you are interested in:

Breast Augmentation (implants)	Breast Lift/Reduction
Tummy Tuck	Liposuction
Thigh/Buttock Lift	Gynecomastia Surgery
Lip Augmentation	Chin Augmentation
Face Lift	Neck Lift
Brow Lift	Eyelid Surgery
Rhinoplasty (nose surgery)	Ear Surgery
Skin Care Products (Obagi, Nia24)	Vaginal Rejuvenation
Reconstructive Surgery	Injectable Treatments (Botox, Juvederm)

Previous Surgeries/Hospitalizations:

Medications:

Please list any medications you are taking:
(include Vitamins, Herbal supplements, Birth control pills, etc.)

Do you have any **Allergies** to medications, food, etc.?

Medical History:

Height: _____ Weight: _____
Have you ever been pregnant? _____ If yes how many times? _____
How many children do you have? _____ Are you pregnant now? _____
When was your last menstrual cycle? _____
Have you gained or lost a significant amount of weight in the last year? _____
When was your last mammogram? _____
When was your most recent physical? _____
Where? _____
Did you have an EKG? _____ Chest X-ray? _____
Do you smoke? _____ If yes, how much per day? _____
Does anyone in you household smoke? _____
Do you consume alcohol? _____ If yes, how much per day? _____
Do you drink coffee, tea, other caffeinated beverages? _____
How much per day? _____

Emotional History:

Do you have any significant emotional problems? _____ If yes, please explain _____
Have you ever had Psychiatric/Psychological Care? _____ If yes, please explain _____
Have you ever been diagnosed with Body Dysmorphic Disorder? _____

Surgery Related History:

Have you ever had a bad reaction while being put to sleep for surgery? _____
Have any of your family members ever had problems with anesthesia? _____
Do you bleed easily from cuts, surgery, tooth extractions? _____
Do you bruise easily, form large scars or keloids? _____

Family Medical History:

Do any of your relatives have any of the following (if yes, who):

Tuberculosis	
Cancer	
Diabetes	
Epilepsy	
Heart Disease	
High Blood Pressure	
Lung Disease	
Kidney Disease	
Blood or Bleeding Disorder	
Asthma	
Mental Disorders	

Review of systems:

Do you have or have you had any of the following? *(Please check yes or no)*

	YES	NO		YES	NO
AIDS or HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Back problems	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in legs	<input type="checkbox"/>	<input type="checkbox"/>	Nervous breakdown	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	Nose/throat problems	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric condition	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
Ear/eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Transfusion	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the information provided on this form is true and accurate and there are no omissions from my medical history. I am responsible to notify the office and the physician if any changes occur in my medical condition. If I fail to keep the doctor informed of my full medical history, I may be at an increased risk for complications or unexpected results from the planned treatments.

Patient (or Responsible Party) Signature

Date

Authorization for Photography and Use of Photographs:

I authorize Dr. Gorodisky and the West Coast Plastic Surgery Center, Inc. to take photographs, images, video, etc. as may be deemed necessary to document and plan my treatment and outcomes. I authorize the use of these images for the purpose of public education, professional advancement, medical education, for insurance purposes, and for promotion of the practice. My identifying information will not be used in these photographs. I authorize my photographs to be shown to prospective patients and on Dr. Gorodisky's website. I may request to have those photos removed at any time.

Patient (or Responsible Party) Signature

Date

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Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment by being diligent in all aspects of your care. Please understand that payment of your bill is necessary for us to continue to provide treatment for you. We request that you read and sign this Financial Policy prior to initiating any treatment.

- All Patients must complete the Patient Information forms prior to seeing the doctor
- Full payment or co-payment/deductible is due at the time of service
- We accept Cash, Checks, and Credit Cards
- Any bank charges for returned checks will be added to the balance
- Financing is available through Care Credit

This office participates with the following insurance companies:

- Blue Cross
- Blue Shield
- United Health/Pacificare
- Signa
- Aetna
- HealthNet
- Medicare

If you have another type of insurance and we are not a participating provider, we will help you to submit your claim, and the reimbursement will be provided to you by your insurance company according to your policy.

To reserve a surgery date, a non-refundable deposit of \$500 is required and will be credited toward your total surgery fee. If the surgery date is to be changed, the deposit will be applied for the new date. Payment in full is due at the time of your preoperative visit, which is usually within 2 weeks of the surgery date.

I have read and understand the Financial Policy. By signing below I indicate my agreement with the above statements.

Patient (or Responsible Party) Signature

Date

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Yuly Gorodisky, D.O.
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Occasionally we may need to contact you regarding your medical care, please check all that apply.

I wish to be contacted in the following manner:

Home Telephone: _____

Leave a Message with detailed information

Leave a Message with a call back number

Work Telephone: _____

Leave Message with detailed information

Leave Message with a call back number

Written Communication

Mail to home address

Fax to this telephone number: _____

I hereby give my permission for the West Coast Plastic Surgery Center, Inc. and Associates to disclose the information regarding my treatment to:

Spouse: _____

Son/Daughter: _____

Parents: _____

Other: _____

Physician: _____

In signing this release, I authorize my medical records to be faxed or mailed upon my request.

Patient (or Responsible Party) Signature

Date

Insurance Information (if applicable):

Primary Insurance Company _____
Claims Address _____
Telephone Number _____
ID # _____ Group Name/# _____

Subscriber(primary insured) _____
Subscriber SS# _____ Birth Date _____
Subscriber's employer _____
Relationship of Patient to subscriber _____

Secondary Insurance Company _____
Claims Address _____
Telephone Number _____
ID # _____ Group Name/# _____

Subscriber(primary insured) _____
Subscriber SS# _____ Birth Date _____
Subscriber's employer _____
Relationship of Patient to subscriber _____

Assignment of Insurance/Medicare Benefits

I, the undersigned, directly assign to the West Coast Plastic Surgery Center, Inc. and Yuly Gorodisky, D.O., all surgical and/or medical benefits otherwise payable to me by Medicare, Private Insurance, or any other health plan for services rendered to me or my dependents. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize any holder of medical or other information about me to release any information necessary to secure the payment of benefits. I authorize any holder of medical or other information about me to release this information to my insurance company; its intermediaries or carriers, to my attorney or another physician's office. I also permit a copy of this information to be used in place of original. This statement will remain in effect until revoked by me in writing.

Patient (or Responsible Party) Signature

Date