WEST COAST
PLASTIC SURGERY CENTER

1801 Solar Drive, Suite 150
Oxnard, CA 93030
(805) 983-1999

Today's Date:_____

Patient's Name:_____Date of Birth:_____
Age:_____
E-mail address (if you would like to be contacted via e-mail) _____
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/SlimLipo/VASER Liposelection
Thigh/Buttock Lift	Gynecomastia Surgery
Lip Augmentation	Chin Augmentation
Face Lift/Quick Lift/Lifestyle Lift, Neck Lift	Ear Surgery
Brow Lift	Eyelid Surgery
Rhinoplasty (nose surgery)	Vaginal Rejuvenation
Skin Care Products (Obagi, Vivite, Latisse)	Skin Tightening (Pelleve, Vela Shape)
Reconstructive Surgery	Injectable Treatments (Botox, Juvederm, Radiesse)

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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?_____

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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	❑	❑	Hepatitis	❑	❑
Anemia	❑	❑	High blood pressure	❑	❑
Arthritis	❑	❑	Irregular heart beat	❑	❑
Asthma	❑	❑	Kidney problems	❑	❑
Back problems	❑	❑	Migraine headaches	❑	❑
Blood clots in legs	❑	❑	Nervous breakdown	❑	❑
Blood disorders	❑	❑	Nose/throat problems	❑	❑
Bleeding problems	❑	❑	Pneumonia	❑	❑
Breathing problems	❑	❑	Psychiatric condition	❑	❑
Cancer	❑	❑	Rheumatic fever	❑	❑
Chest pains	❑	❑	Seizures	❑	❑
Colitis	❑	❑	Shortness of breath	❑	❑
Diabetes	❑	❑	Skin cancer	❑	❑
Ear/eye problems	❑	❑	Stomach problems	❑	❑
Epilepsy	❑	❑	Stroke	❑	❑
Heart problems	❑	❑	Thyroid problems	❑	❑
Heart murmur	❑	❑	Tuberculosis	❑	❑
Heart palpitations	❑	❑	Transfusion	❑	❑

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

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Authorization for Photography and Use of Photographs:

The nature of the treatments provided by Dr. Gorodisky and his associates requires thorough documentation of the physical appearance and visual record of the pre treatment and post-treatment results. Therefore it is necessary for patients consent to undergo photography as part of their medical records in order to document the treatments received. By signing below, I authorize Dr. Gorodisky and his staff at 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, and for insurance purposes. My identifying information will not be used in these photographs.

_____

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, Credit and Debit 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
- Cigna
- Aetna
- Medicare
- Regal Medical Group
- Seaview Medical Group

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. If your insurance determines that your procedure is not covered, you will be responsible for payment of fees associated with your treatment.

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 1-2 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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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 to West Coast Plastic Surgery Center, Inc.

_____

Patient (or Responsible Party) Signature Date

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Insurance Information (if applicable):

Primary Insurance Company_____
Claims Address_____
Telephone Number_____
ID #_____ Group Name/#_____

Subscriber(primary insured)_____
Subscirber SS#_____ Birth Date_____
Subscriber's employer_____
Relationship of Patient to subscriber_____

Secondary Insurance Company_____
Claims Address_____
Telephone Number_____
ID #_____ Group Name/#_____

Subscriber(primary insured)_____
Subscirber 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