

THE NADERI CENTER

297 Herndon Pkwy, Suite 101, Herndon, VA 20170

703.481.0002

5454 Wisconsin Ave, Suite 1710, Chevy Chase, MD 20815

301.244.0150

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name

_____ Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Any restrictions for contacting you? No Yes **E-mail** _____

Contact _____ Drivers License # _____

Restrictions: _____ (include State) _____

Age _____ Birthdate ____/____/____ SS# ____-____-____ Sex Female MaleMarital Status Single Married to: _____ Other: _____**Patient's Employer**

_____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes NoAddress _____
Street & Suite # City State Zip**Emergency Contact**

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip**Primary Health Insurance Company**

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____**Insured:** Name _____ DOB _____ Employer _____**Secondary Health Insurance Company**

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____**Insured:** Name _____ DOB _____ Employer _____

I understand **purely cosmetic consultations** carry a \$240 fee that may be applied towards my surgery or procedure. I realize there is a "no show" fee of \$85 if I do not cancel or reschedule at least 24 hours ahead of time. All other consultations will be billed to me &/or my insurance company. I understand that office visit charges are payable in full on the *same day service is rendered*. All payments for surgery are due at least 2 weeks in advance of surgery. If insurance can pay for part of my desired surgery then my insurance may be charged for the office visit(s). I authorize The Naderi Center to bill my insurance company when appropriate. Regardless of insurance coverage, **I am responsible for all bills being paid in full in a timely manner**. I understand that my contract is between The Naderi Center and myself and it is my responsibility to follow through with my insurance.

Signature _____ **Date** _____**E-mail** _____

Please make sure the information and spelling is completely accurate. It is your responsibility to keep this information up to date and inform us of any changes in the future

1. **Please list all present medications**, including **Accutane**, **birth control pills**, hormones, and vitamins, **herbal** supplements, diuretics, **weight loss drugs**, **energy drinks**. Also, **topical** skincare medications or creams including tretinoin (Retin-A), Differin, Metro-gel, etc. **Include over-the-counter medications.**

2. Have you ever had an adverse reactions to any skin related procedures or cosmetics? Yes No
Which? _____

3. Do you have a history of cold sores or fever blisters? Yes No Date of last outbreak? _____

4. What is your ethnic background (for purposes of aesthetic treatments)? _____

5. In response to sun exposure, do you typically tan or burn? _____

Would you consider yourself to have a tan at this point in time? Yes No

6. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

Yes No If so, how much? _____

7. Do you smoke or use any **Nicotine** containing products (i.e. gum, patch, etc)? Yes No

If so, how much? _____ For how long? _____

8. Are you pregnant or breastfeeding? Yes No

9. Are you actively trying to become pregnant currently or in near future? Yes No

10. Are you using, or have you used **Accutane** within the past 12 months? Yes No

11. When was you last normal menstrual period? _____

*** IF YOU ARE TO BECOME PREGNANT, BE SURE TO LET OUR OFFICE KNOW IMMEDIATELY. THIS WILL ALLOW FOR THE PROPER ALTERATIONS IN YOUR SERVICE OR PRODUCT USE TO BE MADE. SOME PROCEDURES OR PRODUCTS ARE CONTRAINDICATED WITH PREGNANCY OR BREAST FEEDING AND MAY BE HARMFUL TO YOUR CHILD! (i.e. Retin-A, Hydroquinone, etc...)**

12. When was your last eye exam? _____ By whom? _____

13. When was your last physical exam? _____ By whom? _____

14. When was your last chest x-ray? _____ EKG? _____

15. Have you had any recent blood work done? Yes No When? _____

16. Please list all physicians presently caring for you & their office phone numbers: _____

17. Have you ever been under psychiatric care? Yes No When? _____
Why? _____

18. Please list all hospitalizations, surgeries and procedures, including cosmetic: (include where, when and why for each):

19. What are your expectations for your appointments with us? _____

20. Do you understand that there is no such thing as “perfection” and that the goal of any cosmetic procedures is “improvement?” Yes No

21. Are you generally a happy and optimistic person? Yes No

22. Do you understand that there are risks associated with all procedures such as infection, allergic reaction, scarring, asymmetry, need for further procedures, dissatisfaction with results, permanent disfigurement, etc? Yes No

23. Do you understand that it is your responsibility to update your information with us - such as name or number changes, allergy, medication or medical history changes, and inform us of any such change? Yes No

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____
(If under 18 then signature and name of parent or guardian)

Print Name: _____

Use additional paper or attach additional forms if necessary. Please print legible and complete all fields.

THE NADERI CENTER FOR COSMETIC SURGERY & SKIN CARE, PLLC

Patient: _____

PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, _____, authorize The Naderi Center for Cosmetic Surgery & Skin Care, PLLC, Shervin Naderi, MD, FACS, and/or his representative(s), to take photographs, slides or videotapes of me or parts of my body for medical purposes to be used for my care, medical presentations, marketing, literature, case presentation. These photographs will not be sold by The Naderi Center or used for other purposes by The Naderi Center. I authorize the use of these images, without compensation to me. I understand that photography is an integral part of cosmetic surgery and important for patient care. **I understand that no surgery or procedure may be done unless I consent to photography;** This is to be able to review before and after results of the surgery or procedure for comparison.

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Naderi and/or The Naderi Center for Cosmetic Surgery & Skin Care, PLLC in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Naderi, for which Dr. Naderi may receive direct or indirect remuneration.
2. **I will not be identified by name in any of the media described above;** however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me.
3. **I CAN CHOOSE TO HAVE MY EYES BLOCKED OR SHADED:** Please check here
4. **I CAN CHOOSE TO ONLY HAVE MY NOSE, LIPS, or NECK VISIBLE:** Please check here
5. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to The Naderi Center. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization. If I do not revoke this authorization, it shall not expire.
6. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Naderi and/or The Naderi Center for Cosmetic Surgery & Skin Care, PLLC.
7. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.
8. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.
9. By consenting I agree to discuss any and all of my concerns with The Naderi Center and not discuss my experience on the internet.

I release and discharge Dr. Naderi and/or The Naderi Center for Cosmetic Surgery & Skin Care, PLLC from all liability that in any way arises out of:

- any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and
- any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact **The Naderi Center** at (703) 481-0002. If under 18, guardian or parent must sign.

Print Name _____

Date _____

Signature _____

Witness _____

**The Naderi Center for Cosmetic Surgery
& Skin Care, PLLC**

Patient Name: _____

Today's Date: _____

THE NADERI CENTER CANCELLATION / RESCHEDULING POLICY

At The Naderi Center, we are dedicated to setting aside appropriate time to meet all of your needs and answer all of your questions. We ask in return that you provide the office with at least **24 hours** "courtesy notice" in the event that you need to cancel or reschedule your appointment.

While our consult fee is normally \$240, you may be charged an \$85 "no show fee" or the full service price of your Aesthetic skincare treatment, if you do not provide such notice. We thank you for your understanding.

NOTICE OF PRIVACY PRACTICES (HIPAA)

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of Protected Health Information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

NAME: _____

SIGNATURE: _____ DATE: _____

Print Name: _____

Patient Initials: _____