DENVER COSMETIC SURGERY – DR. EDMON KHOURY 720-475-8400

Patient Name: _____
First Middle Last

Address: _____
Street & Apt # City State Zip

Preferred Name: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Ext: _____ Is it okay to contact you at work? □ Yes □No

Best Number to Contact: □ Home □ Cell □ Work □ Other: _____

E-mail: _____ Contact Restrictions: _____

Age: _____ Birthdate: _____/_____/_____ Gender: □ Male □ Female

Marital Status: □ Single □ Married to: _____ □ Other: _____

Patient Employer: _____ Occupation: _____

Preferred Pharmacy:_____ Phone Number:_____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____

How did you hear about Dr. Edmon Khoury at Denver Cosmetic Surgery?

□ Internet: □ www.denvercosmeticsurgery.com □Google □Yelp

□Other: _____

□Social Media: □Facebook □Instagram □Pinterest □Twitter □LinkedIn

□Patient: _____

□Doctor: _____

□Salon: _____

□Event: _____ □Seminar: _____

□Magazine: _____ □Newsletter: _____

□Other: _____

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Patient Name:	DOB:
What Procedure are you interested in?	Age:

DO YOU NOW OR HAVE YOU EVER HAD: (please check if yes)

Heart Trouble	
Heart Attack	
Chest Pain	
Palpitation or Irregular Pulse	
Extra Heart Beats	
Stroke	
Signs of a Stroke or Mini Stroke /TIA	
Issues with Local Anesthesia	
High Blood Pressure	
Blood Pressure Abnormalities	
Abnormal EKG	
Heart Disease	
DVT or Pulmonary Embolism	
Dry Eyes	
(if yes Dry Eyes circle severity) **Mild Severe**	
Palsy or Paralysis (weak face)	
Bleeding Tendency or Disorder	
Seizures or convulsions or fainting spells	
Black outs	
Heart Murmur	
Rheumatic Fever	
Shortness of Breath	
Asthma	
Bronchitis	
Tuberculosis	
Pneumonia	
Emphysema	
Coughing or Spitting of Blood	
Vomiting Blood	

Nervous Breakdown	
Nervous Disorder	
Drug Habit	
Self-Destructive Tendencies	
Psychiatric Hospitalization or Care	
Alcoholism or Drug Dependency	
Cirrhosis of the Liver	
Kidney Disorder	
Kidney or Renal Disease	
Major Allergies	
Thyroid Problems	
Goiter or Thyroid Disorders	
Esophageal Varices	
Frequent Indigestion	
Ulcers	
Gastritis	
Colitis	
Problem Constipation	
Skin Disorders	
Arthritis	
Fracture of Neck or Spine	
Airway Obstruction (Nasal)	
Abnormal Bleeding after Tooth Extraction	
Blood Transfusion	
Positive blood test for: HIV, AIDS, Hepatitis	
Any family members with bleeding problems	
Piercing other than the ears	
Restless Leg	
Family history of cancer, heart trouble, stroke	

Please list ALL present medications: (Please include any birth control, hormones, vitamins, herbal medications, diuretics, weight loss drugs and all over-the-counter medications)

_____

_____

_____

_____

Do you have an allergy to any medications, latex, or adhesives? If yes please list ALL allergies.

_____

_____

Have you ever reacted abnormally to any medication? Yes No If yes please list _____

_____

1. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia? □ Yes □ No If yes, when and where? _____

2. Have you ever been on cortisone or steroid treatment? □ Yes □ No When? _____

3. Do you get cold sores? □ Yes □ No If yes, where and how often? _____

4. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol? □ Yes □ No If so, how much? _____

5. Do you smoke? □ Yes □ No If so, how much? _____ For how long? _____

6. Are you pregnant? □ Yes □ No When was your last normal menstrual period? _____

7. Do you have Children? □ Yes □ No If yes, please list names and ages? _____
   _____

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

9. When was your last eye examination? _____ By whom? _____

10. When and where was your last chest x-ray? _____ EKG? _____

11. Who is your personal physician, if any? _____

12. Please any other physicians caring for you? _____

13. Have you ever been under psychiatric care? □ Yes □ No When? _____Why? _____

14. Have you had any recent blood work done? □ Yes □ No Where? _____

15. Please list all surgical and hospitalizations below: (include any procedures done for cosmetic reasons)
SURGICAL OPERATIONS (include details: when, where and why)
_____
_____
_____
_____
HOSPITALIZATIONS (include details: when, where and why)
_____
_____
_____

16. Is there anything else you think the doctor should know?
_____
_____

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

Signature: _____ Date: _____

_____ **Appointment Reminders**

Initials We may use your information to remind you about upcoming appointments. Typically, a brief non-specific message may be left on your answering machine or voicemail. If you have an answering machine or voicemail, we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Denver Cosmetic Surgery/Dr. Edmon Khoury.

Phone Number: _____

Email Address: _____

_____ Yes _____ No

Yes, you may use the above listed phone numbers and/or email addresses for appointment communication.

If no, how else may we contact you regarding this information?

_____

_____ **Use and Disclosure of Information**

Initials I authorize the person(s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Denver Cosmetic Surgery/Dr. Edmon Khoury.

_____ _____

Name of Authorized Person Name of Authorized Person

OR

_____ I do not authorize my information to be disclosed to any other parties.

You may revoke or terminate this authorization by submitting a written revocation to Denver Cosmetic Surgery/Dr. Edmon Khoury. You should contact the Practice Manager or other authorized representative to terminate this authorization.

_____ **Insurance Policy**

Initials Denver Cosmetic Surgery/Dr. Edmon Khoury is not in network with any insurance carriers. Our policy indicates that we will not submit any paperwork to insurance companies, i.e. letters, codes, etc., on behalf of the patient. I understand that it is my sole responsibility to provide any necessary documentation if seeking insurance reimbursement.

_____ **Privacy Practice Notice**

Initials Our Notice of Privacy Practice (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 acknowledgement. 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 can be provided to you, that you understand the contents of our Notice and how it applies to you.

_____ _____ _____

Patient Name: Patient Signature Date

**Please initial each paragraph above*