

Neal Handel, M.D., F.A.C.S.
9201 Sunset Blvd. Ste. 214
West Hollywood, CA 90069
(310)777-6677

PLEASE COMPLETE THIS FORM IN DETAIL

Date _____

(Last name) (First name) (Middle name)

(Street address) (City) (State) (Zip code)

Cell Phone # _____ Work Phone # _____

Date of Birth _____ Age _____ Height _____ Weight _____

E-mail address _____

May we contact you via e-mail? **Y N**

May we contact you at work? **Y N**

May we contact you by cell phone? **Y N**

How you would prefer to be addressed? _____

Sex Male Female Transgender

Married _____ Single _____

Social Security # _____

Drivers License # _____ (need copy)

Occupation _____ Employer _____

How did you hear about us? _____

What procedures are you interested in discussing?

Spouse's Name _____ Occupation _____

Spouse's Employer _____

Emergency Contact _____ Phone Number _____

Primary Insurance Co. _____ (need copy)

(Name and address)

Member # _____ Group # _____

Responsible Party _____

I AUTHORIZE PAYMENT DIRECTLY TO NEAL HANDEL, M.D. FOR THE SURGICAL AND/OR MEDICAL BENEFITS PAYABLE TO ME FOR HIS SERVICES. I ALSO AUTHORIZE DR. HANDEL TO RELEASE INFORMATION REGARDING MY TREATMENT TO MY INSURANCE COMPANY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

Patient's signature (or parent if under 18) Date

CONSENT FOR MEDICAL PHOTOGRAPHY

Photographs are an important part of the medical record. They are used to document a patient's appearance before, during, and after treatment and for professional educational purposes. I hereby grant permission to Dr. Handel and his staff to obtain appropriate medical photographs of me for educational internet media, professional publications and/or medical lectures.

Patient's signature (or parent if under 18)

Date _____

General Medical History

| Yes | No | | Yes | No | |
|------------|-----------|---|------------|-----------|--|
| () | () | Ear, nose, throat trouble? | () | () | Bladder or Kidney Problems? |
| () | () | Bone, joint or back problems? | () | () | Phlebitis, varicose veins? |
| () | () | Are you being treated for Glaucoma? | () | () | Stroke, Polio, Paralysis? |
| () | () | Dizziness, fainting problems? | () | () | Memory loss, amnesia? |
| () | () | Thyroid problems? | () | () | Convulsions, epilepsy? |
| () | () | Asthma, emphysema, shortness of breath? | () | () | Diabetes? |
| () | () | Chronic cough problems? | () | () | Rheumatic fever? |
| () | () | Pain or pressures in the chest, arm, neck? | () | () | Allergies? |
| () | () | Difficulty breathing when lying flat in bed? How many pillows do you need? _____ | () | () | Do you drink coffee? Cups per day _____ Number of years _____ |
| () | () | Swelling of the legs? | () | () | Cold sores? Herpes? |
| () | () | Heart trouble or mitral valve problem, Or chest pains? | () | () | Do you smoke? Number per day _____ Number of years _____ |
| () | () | High blood pressure? | () | () | Do you drink alcohol? Liquor/Beer/Wine (circle) # drinks weekly _____ Number of years _____ |
| () | () | Stomach trouble? | | | |
| () | () | Black tarry stool? | | | |
| () | () | Hepatitis or jaundice (circle)? | | | |

SURGICAL AND ANESTHETIC HISTORY

Yes No

() () **Have you ever had: (please circle)**

- Transfusions
- Anesthetic problems
- Excessive nausea or vomiting after surgery

() () **Within in the past 6 months, which of the following medications have you taken? (Please circle)**

- Cortisone, steroids, ATCH, etc.
- Blood thinners, anticoagulants
- Diuretics-Dyazide, etc.
- Insulin, other diabetic medications
- Digitalis, heart medicines, Orgard or Inderol etc.

() () **Has any member of your family had a major complication during surgery while under Anesthesia?**

(Please specify) _____

Patient's Name (please print) _____

SURGICAL AND ANESTHETIC HISTORY CONT.

Yes No

() () Have you ever had an adverse reaction to: Penicillin, Sulfa, Antibiotics, Aspirin, Vitamin E, Novocain, Morphine, Demoral, Codeine, etc. Tetanus, other serums, Iodine, Merthiolate, Adhesives, or Latex?

(Please specify) _____

() () Have you or any member of your family bled excessively after surgery or tooth extraction?

(Please specify) _____

* Please list in sequence the surgeries you have had. (Including dental and deliveries)

* Were there any complications or problems of any kind with any of them?

*** PLEASE LIST ALL MEDICAL CONDITIONS:**

*** Please list every medication (drug) including any over the counter medications, Supplements and /or Herbal Medications you have been taking in the last month.**

Name of Drug

Strength (dosage) how often?

Dr. who prescribed it?

Patient's Name (please print) _____