Neal Handel, M.D., F.A.C.S.
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Beverly Hills, CA 90210
(310) 203-0511

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?
( )	( )	Stomach trouble?			Liquor/Beer/Wine (circle)
( )	( )	Black tarry stool?			# drinks weekly___
( )	( )	Hepatitis or jaundice (circle)?			Number of years

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)_____