

Tamir Mosharrafa, M.D. P.C.

# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

May we leave a message at this number? YES NO

Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

May we leave a message at this number? YES NO

Cell / Pager: \_\_\_\_\_

May we leave a message at this number? YES NO

Email Address: \_\_\_\_\_

*(We will not give out your email address, it is for our own use)*

Would you like to receive emails to inform you about upcoming specials and events? YES NO

Sex: M F SS# \_\_\_\_\_ - \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Single:  Married:  Other: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Nearest relative not living with you: \_\_\_\_\_

Phone #: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

I authorize my plastic surgeon to take before and post-recovery photographs. I understand that my face will not be shown in these photos and that I am entitled to a copy.

**AUTHORIZATION TO RELEASE INFORMATION:** I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan and disability company. These records can be transmitted by facsimile (FAX).

## ADDITIONAL PATIENT INFORMATION

Primary Care Doctor: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## PLEASE PROVIDE ALL INSURANCE INFORMATION REGARDING CLAIM

### PRIMARY INSURANCE:

Ins. Co. Name: \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Male  Female  D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relationship to patient: \_\_\_\_\_

Employer: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group/claim#: \_\_\_\_\_

Effective date of insurance: \_\_\_\_\_

### SECONDARY INSURANCE:

Ins. Co. Name: \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Male  Female  D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relationship to patient: \_\_\_\_\_

Employer: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group/claim#: \_\_\_\_\_

Effective date of insurance: \_\_\_\_\_

**AUTHORIZATION TO PAY:** I hereby authorize payment directly to the business office of this physician's office for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

**PATIENT SIGNATURE (Parent if minor):** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Tamir Mosharrafa, M.D. P.C.

3301 North 2nd Street  
Phoenix, Arizona 85012  
(602) 230-1464 • Fax (602) 230-1465

## CURRENT INJURY OR PROBLEM

NAME \_\_\_\_\_

DATE \_\_\_\_\_

CURRENT PROBLEM \_\_\_\_\_

RIGHT    LEFT

DATE OF INJURY \_\_\_\_\_ OR

FIRST DATE OF SYMPTOMS \_\_\_\_\_

HOW OCCURRED \_\_\_\_\_

WHERE OCCURRED \_\_\_\_\_

X-RAYS OF \_\_\_\_\_

DATE TAKEN \_\_\_\_\_

WHERE TAKEN \_\_\_\_\_

HOSPITALIZED AT \_\_\_\_\_

ADDRESS \_\_\_\_\_

ADMITTED \_\_\_\_\_

DISCHARGED \_\_\_\_\_

## REVIEW OF SYSTEMS:

| HAVE YOU EVER HAD:           | NO | YES | DATE |
|------------------------------|----|-----|------|
| DIABETES                     |    |     |      |
| CANCER                       |    |     |      |
| ANEMIA                       |    |     |      |
| GOUT                         |    |     |      |
| KIDNEY/BLADDER TROUBLE       |    |     |      |
| HIGH BLOOD PRESSURE          |    |     |      |
| HEART TROUBLE                |    |     |      |
| BLEEDING DISORDER            |    |     |      |
| ASTHMA/MAY FEVER             |    |     |      |
| EPILEPSY/SEIZURES            |    |     |      |
| MENTAL RETARDATION           |    |     |      |
| NEUROLOGIC DISEASE           |    |     |      |
| STROKE                       |    |     |      |
| BLINDNESS/GLAUCOMA           |    |     |      |
| THYROID PROBLEMS             |    |     |      |
| DEAFNESS                     |    |     |      |
| MENTAL ILLNESS               |    |     |      |
| ULCER/STOMACH/BOWEL PROBLEMS |    |     |      |
| RHEUMATIC FEVER              |    |     |      |
| TB/VALLEY FEVER              |    |     |      |
| HEPATITIS                    |    |     |      |
| PNEUMONIA                    |    |     |      |
| ARTHRITIS                    |    |     |      |
| PHLEBITIS                    |    |     |      |
| PROSTATE                     |    |     |      |

## MEDICAL INFORMATION

ARE YOU NOW PREGNANT?       YES       NO

DO YOU SMOKE?               YES       NO

| ALLERGIES FOOD-MEDICINE/REACTION | DATE |
|----------------------------------|------|
|                                  |      |
|                                  |      |
|                                  |      |
|                                  |      |

| MEDICATIONS YOU ARE TAKING: | DATE |
|-----------------------------|------|
|                             |      |
|                             |      |
|                             |      |
|                             |      |

### PAST MEDICAL HISTORY

| OPERATIONS: | DATE |
|-------------|------|
|             |      |
|             |      |
|             |      |
|             |      |

| OTHER HOSPITALIZATIONS: | DATE |
|-------------------------|------|
|                         |      |
|                         |      |
|                         |      |
|                         |      |

| CHRONIC ILLNESSES: | DATE |
|--------------------|------|
|                    |      |
|                    |      |
|                    |      |
|                    |      |

| FAMILY HISTORY: | AGE | STATE OF HEALTH |
|-----------------|-----|-----------------|
| FATHER          |     |                 |
| MOTHER          |     |                 |
| SIBLINGS        |     |                 |
|                 |     |                 |
|                 |     |                 |
|                 |     |                 |
|                 |     |                 |
|                 |     |                 |
|                 |     |                 |

ADDITIONAL MEDICAL HISTORY:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# ACKNOWLEDGMENT OF PRIVACY PRACTICES

Tamir Mosharrafa, M.D., PC  
3301 N 2<sup>nd</sup> Street  
Phoenix, Arizona 85012  
(602) 230-1464 ° (602) 230-1465

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of my healthcare provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my healthcare provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgment:

\_\_\_\_\_  
\_\_\_\_\_

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## For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following reason:

- |  |   |
|--|---|
| <input type="checkbox"/> The patient refused to sign | <input type="checkbox"/> Communication barriers |
| <input type="checkbox"/> Emergency situation         | <input type="checkbox"/> Other _____            |

PHOTOGRAPHIC RELEASE AND CONSENT  
FOR

Tamir Mosharrafa, M.D. and the specialists under the supervision of  
Tamir Mosharrafa, M.D.; or within the practice of Tamir Mosharrafa,

M.D., P.C.  
3301 North 2<sup>nd</sup> Street  
Phoenix, Arizona 85012

I understand and accept that I might be recognized from my likeness or case history. Nevertheless, I authorize my plastic surgeon to take before and post-recovery pictures. \*I understand that my face will not be shown in either my before or post-recovery pictures and that I am entitled to a copy of my before and post-recovery pictures.

*\*Does not include facelift, browlift, blepharoplasty, rhinoplasty, or patients treated with Botox®; skin care center or Collagen® patients.*

*Please provide your initials next to each section you agree with and approve:*

\_\_\_\_\_ I found it very helpful having an array of photographs to look at during my consultation; therefore, in order to assist my plastic surgeon with the education of future patients, I hereby authorize the use of my photographs for patient educational purposes.

\_\_\_\_\_ I authorize the use of my photographs, videotapes and case information for other educational settings, including lectures and multi-media presentations for an audience of medical professionals, at which members of the press may be present, and medical, scientific journal articles.

\_\_\_\_\_ I authorize my plastic surgeon to use my pre-operative and post-operative photographs in the following commercial/educational settings; magazine, newspaper articles, and television productions, that my plastic surgeon is involved in, my plastic surgeon's personal web site or web page.

\_\_\_\_\_ I also authorize my plastic surgeon's professional association, the not-for-profit **American Society for Aesthetic Plastic Surgery**, to use my photographs and case information in fulfilling its mission of public education, in any of the following settings: patient education brochures available for purchase; educational videotapes available for purchase; lectures and slide presentations available for purchase; information submitted by the society for periodicals, magazines and web sites for press or internet publication; television programs about plastic surgery; and case studies presented on the Society's web site at [www.surgery.org](http://www.surgery.org).

\_\_\_\_\_ Print Name

\_\_\_\_\_ Patient Signature

\_\_\_\_\_ Date