LISA AIRAN M.D.
PATIENT INFORMATION FORM

_____ _____/_____/_____
REASON FOR VISIT **DATE OF VISIT**

_____ _____ (_____)_____
MR/MRS/MISS **PREFERRED FIRST NAME** **HOME PHONE**

_____ _____ _____ (_____)_____
FIRST NAME **MIDDLE NAME** **LAST NAME** **WORK PHONE**

_____ _____ (_____)_____
ADDRESS **APT.** **MOBILE PHONE**

_____ _____ _____ (_____)_____
CITY **STATE** **ZIP** **FAX**

_____ ☐MALE ☐FEMALE (_____)_____
SOCIAL SECURITY NUMBER **OTHER**

_____ _____ ☐SINGLE ☐MARRIED ☐OTHER
BIRTH DATE **AGE**

_____ _____
SPOUSE'S NAME **E-MAIL ADDRESS**

EMERGENCY CONTACT

_____ _____
FIRST NAME **LAST NAME**

_____
RELATIONSHIP

(_____)_____
PHONE

PREFERRED PHARMACY

_____
NAME

_____
PHONE

EMPLOYMENT INFORMATION

_____
OCCUPATION

_____
COMPANY OR SCHOOL

_____
ADDRESS

_____ _____ _____
CITY **STATE** **ZIP**

MAY WE CALL YOU AT WORK? ☐YES ☐NO

MAY WE LEAVE A MESSAGE FOR YOU AT HOME? ☐YES ☐NO

MAY WE EMAIL TO THE ADDRESS PROVIDED? ☐YES ☐NO

MAY WE TEXT YOU AT THIS NUMBER? ☐YES ☐NO

INSURANCE INFORMATION

_____
PRIMARY INSURANCE COMPANY NAME

_____
NAME OF INSURED

_____
INSURED'S ADDRESS IF DIFFERENT FROM ABOVE

_____ _____
INSURED'S DATE OF BIRTH **INSURED'S SS #**

_____
INSURED'S RELATIONSHIP TO PATIENT

(_____)_____
PHONE

_____
POLICY NUMBER

_____
GROUP NUMBER

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HOW DID YOU HEAR ABOUT DR. AIRAN?
PLEASE CHECK ALL THAT APPLY.

☐ **BRAND/NAME RECOGNITION**

☐ **REFERRING DR.:** _____ ☐ **FRIEND OR RELATIVE:** _____

☐ **INSTAGRAM** ☐ **FACEBOOK** ☐ **YOUTUBE** ☐ **TWITTER**

☐ **MAGAZINE:** ☐ **VOGUE** ☐ **W** ☐ **O MAGAZINE** ☐ **ALLURE** ☐ **LUCKY** ☐ **WOMAN'S WEAR DAILY**

☐ **OTHER MAGAZINE:** _____

☐ **WEBSITE:** ☐ **DRLISAAIRAN.COM** ☐ **GOOGLE** ☐ **BOTOXCOSMETIC.COM** ☐ **REAL SELF**

☐ **OTHER WEBSITE:** _____

PLEASE CHECK ALL THAT INTEREST YOU:

☐ **BOTOX**

☐ **INJECTABLE FILLERS (FOR FINE LINES AND WRINKLES)**

☐ **PRODUCT OR SKIN CARE RECOMMENDATIONS**

☐ **FACIAL PEEL FOR:** ☐ **ACNE** ☐ **SKIN REJUVENATION**

☐ **KYBELLA FOR SUBMENTAL FULLNESS (DOUBLE CHIN)**

☐ **PLATELET RICH PLASMA FOR HAIR RESTORATION AND/OR IMPROVED SKIN TEXTURE**

☐ **GENTLEWAVES (TO IMPROVE SKIN QUALITY)**

☐ **COOLSCULPTING**

☐ **NON-SURGICAL LOWER EYELID LIFT/PERIORBITAL AUGMENTATION (POA)**

☐ **THERMAGE SKIN TIGHTENING**

☐ **SCLEROTHERAPY FOR LEG VEINS**

☐ **LASER TREATMENTS FOR:** ☐ **HAIR REMOVAL** ☐ **SKIN REJUVENATION**
☐ **BROWN SPOTS** ☐ **SKIN RESURFACING** ☐ **FACIAL OR LEG VEINS**
☐ **TATTOO REMOVAL** ☐ **FACIAL REDNESS/ROSACEA** ☐ **SCARS** ☐ **OTHER:**

_____

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PATIENT HEALTH DISCLOSURE STATEMENT

Please answer all questions. **Date** _____

Name: _____ Age _____ Height _____ Weight _____

Are you under a doctor's care? _____ yes _____ no If yes, for what condition? _____

Illnesses (List any serious or chronic illness):

1. _____ 2. _____
3. _____ 4. _____
5. _____

Operations (List all previous surgery):

1. _____ 2. _____
3. _____ 4. _____
5. _____ Other: _____

Habits:

Alcohol: Never Rarely Several Times a Week Daily
Tobacco: Never Rarely Daily Packs per day _____ How long? _____ Cigar/Pipe Yes No

Do you have any of the following?
(Please Circle):

Dentures Capped teeth Bridges Loose teeth Chipped teeth
Hearing aid Gum Disease Glasses Contact Lenses Other Prosthetic Devices:_____

Important Medical Conditions: Have you ever had or received treatment for any of the following?
(Please circle)

Hepatitis, jaundice, cirrhosis, or liver disease?	Yes	No	Blood transfusions?	Yes	No
Asthma, TB, pneumonia, emphysema or chest disease?	Yes	No	HIV or AIDS?	Yes	No
Heart attack, angina, palpitations or irregular heart beats?	Yes	No	Anemia or blood disorder?	Yes	No
Shortness of breath, or fainting spells	Yes	No	Chronic or recent cough?	Yes	No
Rheumatic fever or congenital heart disease?	Yes	No	Abnormal or excessive bleeding?	Yes	No
High blood pressure or Low blood pressure?	Yes	No	Hives, rashes, or skin diseases?	Yes	No
Kidney failure, kidney or prostate problems?	Yes	No	Alcohol abuse or alcoholism?	Yes	No
Migraines, headaches or chronic head pain?	Yes	No	Drug abuse or addictions?	Yes	No
Eating disorder, anorexia, or bulimia?	Yes	No	Diabetes or abnormal "blood sugar"?	Yes	No
Lupus, arthritis, or autoimmune disease?	Yes	No	Thyroid problems?	Yes	No
Psychological or emotional problems?	Yes	No	X-ray treatments or radiation therapy?	Yes	No
Nervous breakdown or personality disorder?	Yes	No	Adverse or unusual reaction to anesthesia?	Yes	No
Phlebitis, blood clots or varicose veins?	Yes	No	Abnormal healing or poor scar formation?	Yes	No
Stroke, seizures, Bell's palsy or neurological problems?	Yes	No	Edema, persistent or unusual swelling?	Yes	No
Shingles, cold sores, fever blisters or oral herpes?	Yes	No	Venereal disease?	Yes	No
Stomach ulcers?	Yes	No	Anxiety or "panic attacks"?	Yes	No
Recent weight gain or loss?	Yes	No	Anaphylaxis?	Yes	No

Other Medical Conditions (Explain): _____

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Drugs and Medicines: Have you, within the last 6 months, taken any of the following?
(If yes, please circle)

Accutane	Yes	No	Anticoagulants or blood thinners?	Yes	No
Cortisone, prednisone, or ACTH?	Yes	No	Pain pills?	Yes	No
Diuretics or water pills?	Yes	No	Homeopathic or herbal medicines?	Yes	No
Heart medication, Digitalis, Lanoxin?	Yes	No	Stimulants, appetite suppressants, diet pills?	Yes	No
Blood pressure medication?	Yes	No	Sedatives, tranquilizers, or sleeping pills?	Yes	No
Nitroglycerin?	Yes	No	Antidepressants, antipsychotics or nerve pills?	Yes	No
Steroids or body building drugs?	Yes	No	Recreational or illegal drugs?	Yes	No
Headache or migraine medications?	Yes	No	Phen-Phen, or Redux?	Yes	No
Seizure medication?	Yes	No	Birth Control Pills?	Yes	No
Antibiotics?	Yes	No	Asthma Meds, inhalers etc?	Yes	No
Insulin, Orinase or similar drugs?	Yes	No			

Please List Medications Taken: _____

Medications that cause bleeding: Have you taken any of the following in the last 2 weeks?
(If yes, please circle)

Aspirin or aspirin containing medications?	Yes	No	Vitamin E? (Excluding multivitamins)	Yes	No
Ibuprofen, (Motrin, Advil, Nuprin) containing products?	Yes	No	Anti-inflammatories or muscle relaxants?	Yes	No

Allergies and Sensitivities: Is there any history of skin reaction or other illness following the administration of:
(If yes, please circle)

Penicillin, Sulfa, or other antibiotics?	Yes	No	Tetanus toxoid or serum?	Yes	No
Morphine, Codeine, Demerol or narcotic?	Yes	No	Dairy products?	Yes	No
Novocaine, Lidocaine, or local anesthetics?	Yes	No	Tincture of Benzoin?	Yes	No
Iodine, Betadine, Chlorhexidine, or Phisohex?	Yes	No	Adhesive tape?	Yes	No
Epinephrine	Yes	No	Latex rubber?	Yes	No
Other drugs or medicines? (List):	Yes	No			

Pregnancy:

Are you now pregnant?	Yes	No	Are you breast feeding?	Yes	No
Number of pregnancies? _____			Number of children _____		
Are you sexually active?	Yes	No	Are you currently using birth control?	Yes	No

I certify that the above is true and correct. I realize that withholding information about my medical history could result in serious injury to me or harm to those involved in my care. I am aware that providing either false or incomplete information about my medical and surgical history may result in the cancellation of my proposed surgical procedure and also result in forfeiture of my surgical fees.

_____ **Patient's signature**

_____ **Date**