

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 _____	(_____) _____ PAGER		
SOCIAL SECURITY NUMBER _____	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	(_____) _____ OTHER		
BIRTH DATE _____	AGE _____	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> OTHER	(_____) _____ FAX
SPOUSE'S NAME _____			E-MAIL ADDRESS _____		
<u>EMERGENCY CONTACT</u>			MAY WE CALL YOU AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		
FIRST NAME _____			LAST NAME _____		
RELATIONSHIP _____			MAY WE LEAVE A MESSAGE FOR YOU AT HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO		
(_____) _____			MAY WE EMAIL TO THE ADDRESS PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
HOME PHONE _____			<u>INSURANCE INFORMATION</u>		
(_____) _____			PRIMARY INSURANCE COMPANY NAME _____		
WORK PHONE _____			NAME OF INSURED _____		
(_____) _____			INSURED'S ADDRESS IF DIFFERENT FROM ABOVE _____		
MOBILE PHONE _____			INSURED'S DATE OF BIRTH _____		
<u>EMPLOYMENT INFORMATION</u>			INSURED'S SS # _____		
<input type="checkbox"/> FULL TIME	<input type="checkbox"/> FULL TIME STUDENT	<input type="checkbox"/> RETIRED	INSURED'S RELATIONSHIP TO PATIENT _____		
<input type="checkbox"/> PART TIME	<input type="checkbox"/> PART TIME STUDENT	<input type="checkbox"/> OTHER	(_____) _____		
OCCUPATION _____			PHONE _____		
COMPANY OR SCHOOL _____			POLICY NUMBER _____		
MANAGER'S NAME _____			GROUP NUMBER _____		
ADDRESS _____					
CITY _____	STATE _____	ZIP _____			

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

BRAND/NAME RECOGNITION

REFERRING DR.: _____ FRIEND OR RELATIVE: _____

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

OTHER MAGAZINE: _____

NEWSPAPER: NY TIMES DAILY NEWS NY POST OTHER _____

TELEVISION: OPRAH TYRA BANKS CNN GMA FOX NEWS

OTHER TELEVISION: _____

WEBSITE: DRLISAAIRAN.COM GOOGLE BOTOXCOSMETIC.COM ASLMS

OTHER WEBSITE: _____

PLEASE CHECK ALL THAT INTEREST YOU:

BOTOX

INJECTABLE FILLERS

PRODUCT OR SKIN CARE RECOMMENDATIONS

FACIAL PEEL FOR: ACNE
 SKIN REJUVENATION

GENTLE WAVES

VIBRADERM

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