PLEASE WRITE CLEARLY! DATE: _____

PATIENT'S FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____

SEX: _____ DOB: _____ SOCIAL SECURITY: _____ DRIVERS LICENSE #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____

Are you interested in receiving information on new information and discounts? Yes ☐ No ☐

OCCUPATION: Advertising/Agriculture/Architecture/Art & Entertainment/Aviation/Childcare/Construction & Maintenance/Education/Engineering/Financial service/Executive/Healthcare/Human Resources/ Insurance/Internet/Law/Law Enforcement/Marketing/Real Estate /Retail/ Telecommunications/ OTHER: _____

EMPLOYED BY: _____
EMPLOYER'S ADDRESS: _____
NAME OF SPOUSE: _____
SPOUSE BIRTH DATE: _____
SPOUSE EMPLOYED BY: _____
EMPLOYER'S ADDRESS: _____
WORK PHONE NO.: _____

REFERRED BY: _____

NAME AND ADDRESS OF CLOSEST RELATIVE (IN CASE OF EMERGENCY)
NAME: _____ RELATIONSHIP TO PATIENT: _____
ADDRESS: _____ PHONE NO.: _____

PLEASE LIST ALL INSURANCE INFORMATION COMPLETELY
DO YOU HAVE MEDICARE: _____ POLICY NO.: _____
DO YOU HAVE MEDI-CAL: _____ POLICY NO.: _____

NAME OF INSURANCE COMPANY: _____ (If cash patient, please write "**CASH**")
NAME OF POLICY HOLDER: _____
POLICY HOLDER'S DATE OF BIRTH: _____
RELATIONSHIP TO THE INSURED: _____
SUBSCRIBER OR ID NO.: _____
GROUP NO.:_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ABOVE NAMED PHYSICIAN OF THE SURGICAL AND /OR MEDICAL BENEFITS , IF ANY. OTHERWISE PAYABLE TO ME FOR HIS SERVICES AS DESCRIBED ON ATTACHED CLAIM.

X SIGN:_____ DATE: _____

PAYMENT OF SERVICES:
I REALIZE THAT THIS MAY NOT REPRESENT THE FULL PAYMENT FOR SERVICES RENDERED AND I WILL BE RESPONSIBLE FOR THE BALANCE DUE.

X SIGN: _____ DATE: _____

AUTHORIZATION TO RELEASE INFORMATION:
I HEREBY AUTHORIZE ABOVE NAMED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGN:_____ DATE: _____

Douglas Hamilton, M.D.
Diplomate, American Board of Dermatology
Shanah Gavia, MPA-C

450 N. Bedford Drive, Ste 111
Beverly Hills, CA 90210
(310) 271-6663

6325 Topanga Canyon Blvd, Ste 301
Woodland Hills, CA 91367
(818) 884-7150

COSMETIC PATIENT QUESTIONAIRE
PLEASE PRINT IN INK

Name: _____ Age: _____ Referred By: _____

Please tell us the cosmetic concern that brings you to see Dr. Hamilton or our PA today:

_____

_____

_____

PRIOR COSMETIC SURGERY HISTORY
Please list all cosmetic surgical procedure (including injections or implants) that you have had done, the date, and the doctor who performed the procedure. Please note any complications.

_____

_____

_____

PAST MEDICAL HISTORY
Do you have any health problems? YES / NO Please list them:

_____

What medicine do you take (include any substance which you take by mouth other than food)?

_____

_____

What medicine are you allergic to (if any)?

_____

_____

_____

DO YOU HAVE ANY ELECTRICAL IMPLANTS (PACEMAKERS, COCHLEAR IMPLANTS)? YES / NO

DO YOU HAVE ANY FACIAL IMPLANTS (CHIN, CHEEK OR GORTEX)? YES / NO

Check off all the things that concern you:

FACE ISSUES

- ☐ Wrinkles
- ☐ Scars
- ☐ Brown spots
- ☐ Redness
- ☐ Sun damage
- ☐ Broken blood vessels
- ☐ Deep smile lines
- ☐ Dark under eye circles
- ☐ Deep forehead lines
- ☐ Sagging brows
- ☐ Sagging facial skin
- ☐ Loose neck skin
- ☐ Jowls
- ☐ Sunken cheeks
- ☐ Small cheekbones
- ☐ Thin lips
- ☐ Nose bump
- ☐ Facial hair
- ☐ Daily skin care

BODY ISSUES

- ☐ Body sun damage
- ☐ Cellulite
- ☐ Stretch marks
- ☐ Loose body skin
- ☐ Pockets of fat (e.g. love handles)
- ☐ Spider veins of the legs
- ☐ Varicose veins
- ☐ Aged hands
- ☐ Body hair

Douglas Hamilton, M.D.

Assistant Clinical Professor UCLA School of Medicine
Diplomate of American Board of Dermatology
Dermasurgery

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Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice.

I understand I can obtain this practice's current Notice of Privacy Practices upon request or download them at any time from the practice website: douglashamiltonmd.com.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____