

		TEXSTIC SURGERT		
	Health Ir	formation as of (Please Print Legibly & Fill In or Corr	(enter today's date) rect All Fields)	
Patient's Name				
		Last	First	Middle
		When did you last have an		
Height	Weight	EKG?	Chest x-ray?	
General Health:	Good Fair	Poor		
IF NOT GOOD, PLEASE EX	KPLAIN:			
Previous Surgeries wit	h dates: (Including	cosmetic)		
Have you ever had any If YES, PLEASE EXPLAIN: Have you had children? □ Health Problems past a	INo 🗗Yes	If Yes, please indicate number of children:	□No □Yes	
-				
Diabetes		□High Blood Pressure	Heart Problems	
□Epilepsy		Lung/Breathing Problems	□Bleeding/Clotting Proble	ems
⊐Cancer		□Diabetes		
⊐Other:				
Please explain all positive				
	Alcohol (tion of the following? Coffee or Tea Social Drugs (marijuana, co he counter, vitamins, and herbal medications take		
Drug or Latex Allergies	s: (please indicate if r	one)		
Primary Physician		Phon	e	· · · · · · · · · · · · · · · · · · ·
Date of last physical: CONSENT TO TAKING PHOTOGRA BODY, UNDER THE FOLLOWING C	PHS IN CONNECTION WITH	THE MEDICAL SERVICES WHICH I AM RECEIVING FROM FR. HOP	FMAN, I CONSENT THAT PHOTOGRAPHSMAY BE TAKE	N OF ME OR PARTS OF MY
2. These photog	raphs shall be used for med	consent of my physician and either by my physician or person of h cal records ONLY, unless in the judgment of my physician, medica ided that my identity is not revealed by the photographs.		e. In that event I agree that
The above information	is accurate and co	mplete to the best of my knowledge.		
Signature:			Date:	



DARYL K. HOFFMAN MD

Address	Patient's Name											
Home Phone Street & Apt # City Street Zip Home Phone Cell Phone Other Phone Zip Age Birthdate / / SS# Gender Male Female Marital Status Single Married to: SS# Gender Other: Patient's Employer Occupation Other: Other: Other: Work Phone Ext: May we contact you at work? Yes No Address Street & Suite # City State Zip Google.com TYshcoom TAmerican/Healthand Beauty.com TSmartipo.com TCellulaze.com To obje.com Tothoucom TWelp.com TAmerican/Healthealthand Beauty.com TSmartipo.com TCellulaze.com To obje.com Tothoucom TWelp.com TAmerican/Healthealthealthealthealthealthealthealth	Address		Firs	t			Middle				Last	
E-mail			Street &	Apt #			(City		State	1	Zip
Age Birthdate / / SS# - Gender Male Female Martial Status Single Married to: Occupation Other: Occupation Patient's Employer Occupation Occupation Occupation Occupation Address Street & Sulle # City State Zip How did you hear about Dr. Hoffman? (Mark al that apply) City State Zip Breask11:0n DiverVout Look com Pealeston YamericanHealthan Beauty.com Other: Other Breask11:0n DiverVout Look com Pealeston YamericanHealthan Beauty.com Other: Doto:	Home Phone			Cell	Phone			0	ther Ph	ione		
Marital Status Single Marited to: Occupation Patient's Employer Occupation Occupation Work Phone Ext: May we contact you at work? Yes No Address Street & Suite # City State Zp How did you hear about Dr. Hoffman? (Mark all that apply) Geogle.com Other: Other City State Zp How did you hear about Dr. Hoffman? (Mark all that apply) AmericanHealthand Beauty.com Smartlipo.com Other: Collegescon Other: Collegescon Other Collegescon Other Collegescon Other Other Doctor: Collegescon Other Collegescon Collegesco	E-mail				W	ould you like	e to receive en	nails with o	our new	sletter and s	pecials? 🗆	JYes ⊡No
Patient's Employer Occupation Work Phone Ext: May we contact you at work? Yes No Address	Age	Birthdate	/	/	SS#	-	-	Ger	nder	Male	🗖 Fem	nale
Work Phone	Marital Status	Single	🗖 Mar	ried to:	-			O	ther:			
Address	Patient's Employer	,		-			Occupation					
Address	Work Phone			Ext:		May	we contact	you at wo	ork?	🗖 Yes	🗖 No	
How did you hear about Dr. Hoffman? (Mark all that apply) Caludaze.com Caludaze.com Breast N1 com Corogle.com Caludaze.com Color Provestor Look.com Realisticom Other Website: Color Provestor Look.com	Address							•				
Google.com Yahoo.com PYelp.com ArmericanHealthand Beauly.com Smartlipo.com Clelulaze.com Breass411.com CleveYour Look.com ReadSelt.com OvouPlasticSurgeryGuide.com Obter // Website: TV Magazine Newsletter Doctor: Doctor: Emergency Contact or Responsible Party Name			Street 8	Suite #				City		St	tate	Zip
BreasH11.com ILoveYour Look.com RealSelf.com YourPlasticSurgeryGuide.com Other Website: TV IMagazine Newspaper Newsletter IDoctor: FriendRelative: Other: IDoctor: IDoctor: Emergency Contact or Responsible Party Other: IDoctor: IDoctor: Address City/ State/Zip Phone IDoctor: Primary Health Insurance Company (if applicable) IPlease check if you decline to provide insurance information Policy # Group # Effective Date Referral Required? No Yes Copay? Insured Name: DOB Employer Purpose for your visit today: Mormmy Makeover (Breastiff/Aug, Turmy) 2 zerona (Non Invasive Lipocontouring) Skin Resurfacing (Laser, Peel, Etc.) Tuck) ID and the set in the se	low did you hear a	about Dr. Hoff	man? (M	Mark all that a	pply)							
ITV Magazine Newspaper INewsletter Doctor: Emergency Contact or Responsible Party Name Relationship to Patient Address City/ State/Zip Phone Primary Health Insurance Company (if applicable) IPlease check if you decline to provide insurance informatie Policy # Group # Effective Date Referral Required? No Yes Copay? Insured Name: DOB Employer Purpose for your visit today: Mommy Makeover (Breastlif/Aug, Turmy) Carcon (Non Invasive Lipocontouring) Additional Areas of Interest: (mark all that apply) Body Procedures Other Procedures Blepharoplasty (Reseld Lift) Turk) Turk) 2 zerona (Non Invasive Lipocontouring) Skin Resurfacing (Laser, Peel, Etc.) Turk) Breast Augmentation (Saline/Gel) Skin Care for: Brave of rotehead Lift Breast Reduction Sun Damage Skin Care for: Frazel (Rigmen Wrinkles) Breast Reduction Skin Care for: Breast Reduction Bisetast Reduction Sun Damage Scaring Breast Reduction Breast Reduction Skin Care for: Scaring	Google.com	□Yahoo.co	m				canHealthand Be	eauty.com	⊡Sm	artlipo.com	□Ce	ellulaze.com
Friend/Relative:								de.com				
Name Relationship to Patient Addresss City/ State/Zip Phone Primary Health Insurance Company (if applicable) Please check if you decline to provide insurance informative Policy # Group # Effective Date Referral Required? No Yes, \$ Insured Name: DOB Employer Purpose for your visit today:		□ Magazin	e	□Newspa	•		etter		D Do	ctor:		
Address	Emergency Contac	t or Respon	sible Pa	ty		_						
Primary Health Insurance Company (if applicable) Please check if you decline to provide insurance information of the point of							Patient					
Policy # Group # Effective Date Referral Required? No Yes Copay? No Yes, \$ Insured Name: DOB Employer Employer Purpose for your visit today:	Address				City/	State/Zip			Pr	ione		
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3425 S. Bascom Ave. Suite 100 Campbell, CA 95008 805 El Camino Real, Suite A, Palo Alto, CA 94301



Chief Privacy Officer

Jeanette Ross (408) 371-1118 (650)325-1118

It is Daryl K. Hoffman, M.D. Inc.'s policy that treatment NEVER be conditioned on the signing of this acknowledgement of receipt of Notice of Privacy Practices. In addition, no retaliatory action will be tolerated from staff in response to a patient's decision not to sign this acknowledgement.

By signing this document, I acknowledge that I have received a copy of Daryl K. Hoffman, M/D., Inc.'s Notice Privacy Practice.

Signature

Date _____

Print Name

If not signed by patient, please indicate relationship:

Parent or guardian of minor patient

Personal representative of an incompetent patient



Financial Responsibility

, have read, understood and agreed to the terms and conditions

here within.

Ι,

While your current Cosmetic Procedure may not qualify for insurance coverage, you may elect reconstructive services in the future. Please complete **ALL** of the following.

It is our commitment to provide the best care and services to our patients. We regard your complete understanding of your financial responsibilities as an essential component of your care.

Please initial all spaces below

Our practice does not contract with any insurance companies. All fees for cosmetic and reconstructive services are due in full prior to services performed.

Surgical fees are due 14 days prior to surgery.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand with any surgical procedure, occasionally a secondary, revision or touch-up is necessary. Should this be the case, the surgeon's fee may not be charged, however there may be a facility and/or anesthesia and/or supply fee. This shall depend on the nature of the procedure and does not include additional procedures requested by the patient. As a courtesy we are happy to bill your insurance company.

Insurance services are negotiated by insurance companies and sometimes denied. We will notify you in this case, and if your company offers a benefit payment other than that of the quoted cost of your treatment.

Your insurance company may elect to send your benefits payment directly to you. Therefore, the charges for your care and treatment are due prior to services rendered. If you have questions, or would like help securing financial assistance, please let us know so we can put you in contact with the appropriate staff member.

You acknowledge that the insurance information that you have provided is correct and current. It is your responsibility to notify us if there is any change in your insurance coverage.

You acknowledge that you are aware that our Doctor's and the facility fees are separate from *Other Fees* such as pathology, anesthesia, lab fees, etc.. Other fees shall be additionally billed as such.

We will assist you by providing with fees and codes for all services rendered. We will bill insurance and provide appropriate documentation to assist you with reimbursement. We will assist you to the very best or our ability.

By signing this form, you knowledge that Dr. Daryl K. Hoffman are "Out of Network" providers, and are aware and agree to the afore mentioned policies. You acknowledge that it is your responsibility to chose either an "In" or "Out" of network provider. Your signature also authorizes our office to provide your insurance company with requested information.

Patient Signature

Date

Print Name of Beneficiary, Guardian, or Personal Representative

Date

3425 S. Bascom Ave. Suite 100 Campbell, CA 95008 805 El Camino Real, Suite A, Palo Alto, CA 94301