DARYL K. HOFFMAN MD
PLASTIC SURGERY

# Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

**Patient's Name** _____
Last First Middle

Height Weight When did you last have an EKG? Chest x-ray?

**General Health:** ❒Good ❒Fair ❒Poor

IF NOT GOOD, PLEASE EXPLAIN:

_____
_____
_____

**Previous Surgeries with dates: (Including cosmetic)**

_____
_____
_____

**Have you ever had any complications or after effects from any of these operations?** ❒No ❒Yes
If YES, PLEASE EXPLAIN:_____
Have you had children? ❒No ❒Yes If Yes, please indicate number of children:_____
**Health Problems past and Present:** (mark all that apply)

❒Diabetes ❒High Blood Pressure ❒Heart Problems

❒Epilepsy ❒Lung/Breathing Problems ❒Bleeding/Clotting Problems

❒Cancer ❒Diabetes ❒Tuberculosis

❒Other:_____
Please explain all positive responses:_____

_____

**What is your approximate daily consumption of the following?**

Tobacco_____ Alcohol_____ Coffee or Tea_____ Social Drugs (marijuana, cocaine, ETC.)_____
**Medications:** (include all prescriptions, over the counter, vitamins, and herbal medications taken regularly)
_____
_____
_____

**Drug or Latex Allergies:** (please indicate if none)

_____
_____

**Primary Physician** _____ Phone_____
Date of last physical:_____

CONSENT TO TAKING PHOTOGRAPHS IN CONNECTION WITH THE MEDICAL SERVICES WHICH I AM RECEIVING FROM FR. HOFFMAN, I CONSENT THAT PHOTOGRAPHSMAY BE TAKEN OF ME OR PARTS OF MY BODY, UNDER THE FOLLOWING CONDITIONS:

1. The photographs may be taken only with consent of my physician and either by my physician or person of his choice
2. These photographs shall be used for medical records ONLY, unless in the judgment of my physician, medical research, education, or science will benefit by their use. In that event I agree that they may be used for such purposes, provided that my identity is not revealed by the photographs.

**The above information is accurate and complete to the best of my knowledge.**

**Signature:**_____ **Date:**_____

DARYL K. HOFFMAN MD
PLASTIC SURGERY

(Please Print Legibly & Fill In or Correct All Fields) ❒Filled out online

**Patient's Name** _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

E-mail _____ Would you like to receive emails with our newsletter and specials? ❒Yes ❒No

Age _____ Birthdate ___/___/___ SS# ___-___-___ Gender ❒ Male ❒ Female

Marital Status ❒ Single ❒ Married to: _____ ❒ Other:

**Patient's Employer** _____ Occupation _____

Work Phone _____ Ext: _____ May we contact you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

**How did you hear about Dr. Hoffman?** (Mark all that apply)

❒ Google.com ❒Yahoo.com ❒Yelp.com ❒AmericanHealthand Beauty.com ❒Smartlipo.com ❒Cellulaze.com
❒Breast411.com ❒LoveYour Look.com ❒RealSelf.com ❒YourPlasticSurgeryGuide.com ❒Other Website: _____
❒ TV ❒ Magazine ❒Newspaper ❒ Newsletter ❒ Doctor: _____
Friend/Relative: _____ ❒Other: _____

**Emergency Contact or Responsible Party**

Name _____ Relationship to Patient _____
Address _____ City/ State/Zip _____ Phone _____

**Primary Health Insurance Company** (if applicable) ❒Please check if you decline to provide insurance information

Policy # Group # Effective Date
Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $
Insured Name: _____ DOB _____ Employer _____

**Purpose for your visit today:** _____

**Additional Areas of Interest:** (mark all that apply)

**Facial Procedures**
- ❒ Blepharoplasty (Eyelid Lift)
- ❒ Skin Resurfacing (Laser, Peel, Etc.)
- ❒ Rhinoplasty (Nose Reshaping)
- ❒ Brow or Forehead Lift
- ❒ Earlobe Repair
- ❒ Facial Liposuction (Neck, Jowls)
- ❒ Face or Neck Lift
- ❒ Fuller Lips (Injectables)
- ❒ Otoplasty (Ear Pinning)
- ❒ Botox® Cosmetic (Injectable)
- ❒ Wrinkle Fillers (Injections)
- ❒ Other _____

**Body Procedures**
- ❒Mommy Makeover (Breastlift/Aug, Tummy Tuck)
- ❒ Breast Augmentation (Saline/Gel)
- ❒ Breast Reconstruction
- ❒ Breast Reduction
- ❒ Mastopexy (Breast Lift)
- ❒ Nippe Reduction or Inversion
- ❒ Abdominoplasty (Tummy Tuck)
- ❒ Brachioplasty (Arm Lift)
- ❒ Full Body Lift
- ❒ Liposuction (Vaser, Smartlipo, Body Jet)
- ❒ Thigh or Buttock Lift

**Other Procedures**
- ❒ Zerona (Non Invasive Lipocontouring)
- ❒ Acoutic Wave Therapy
- ❒ Fraxel (Pigmen s/Wrinkles)
- ❒Latisse (Treatment for Eyelash Growth)
- ❒Sun Damage
- ❒Skin Care for:
  - ❒Lines & Wrinkle
  - ❒Coarse Texture
  - ❒Scarring
  - ❒Discoloration
  - ❒ Sun Damage
  - ❒ Facial Capillaries

I understand that office visit charges are payable on the day service is rendered.

**Signature:** _____ **Date** _____

(For Office Use) Consultant : _____ Notes: _____


# Acknowledgement of Receipt of Notice of Privacy Practices

***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

DARYL K. HOFFMAN MD
PLASTIC SURGERY

# Financial Responsibility

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

here within.

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