GLENN VALLECILLOS, M.D.

Patient registration

The information contained herein is confidential. It will not be released unless you authorize us to do so. Please print clearly.

Name_____ Date of birth __ __/__ __/__ __ Age __ __
last first middle

Social Security __ __ __ - __ __ - __ __ __ __ Driver's license _____

Home address _____ E-mail address _____

City/state/zip _____ Home phone (__ __ __) __ __ __ - __ __ __ __

Phone number where we may leave a confidential message (__ __ __) __ __ __ - __ __ __ __

Employer name _____ Your occupation _____

Employer address _____

City/state/zip _____ Phone (__ __ __) __ __ __ - __ __ __ __

Spouse or parent name (circle which) _____

Address _____

City/state/zip _____ Phone (__ __ __) __ __ __ - __ __ __ __

In case of emergency contact _____

Relationship to you _____ Phone (__ __ __) __ __ __ - __ __ __ __

REFERRED BY _____ ***REASON FOR CONSULTATION***_____

Address _____ _____

City/state/zip _____ _____

INSURANCE INFORMATION

Medical insurance _____ Policy/Group # _____

Address _____

City/state/zip _____ Phone (__ __ __) __ __ __ - __ __ __ __

Deductible $ _____ Have you met the deductible this year? _____

Secondary insurance coverage _____

PAYMENT

Payment guaranteed by _____ as services are rendered

Payment by (initial) cash _____ , check _____ , credit card _____, financing _____

I have read and understood the attached medical history form and guarantee payment prior to signing below. I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing I am responsible to pay all non-covered services. A non-refundable 25% of the surgical fee is needed to reserve a surgical date. I hereby authorize the release of pertinent medical information to the insurance carriers.

_____ Date __ __/__ __/__ __

Patient or responsible party's signature

GLENN VALLECILLOS, M.D.

Patient personal health history

Today's date __ __/__ __/__ __

The information contained herein is confidential and will not be released unless you authorize us to do so. Answer all questions to the best of your knowledge. Please print clearly.

Name _____ Date of birth __ __/__ __/__ __
last first middle

Age ____ Height ____ Weight ____ Sex (circle) M F Marital status (circle) S M W D

PHYSICIAN INFORMATION

Referring physician _____ Address _____

Date of your last physical exam __ __/__ __/__ __

HEALTH HISTORY

Do you have or have you had (circle - if yes, give date of occurrence)

AIDS or HIV	no yes	Congenital heart disease	no yes	Kidney Disease	no yes
Arthritis	no yes	Depression	no yes	Leukemia	no yes
Asthma	no yes	Diabetes	no yes	Migraine	no yes
Back problems	no yes	Dry eye	no yes	Pneumonia	no yes
Bladder infection	no yes	Epilepsy	no yes	Scleroderma/lupus	no yes
Bleeding tendency	no yes	Hay fever	no yes	Stomach ulcers	no yes
Bronchitis	no yes	Heart attack	no yes	Stroke	no yes
Cancer	no yes	Hepatitis	no yes	Thyroid disease	no yes
Colitis	no yes	High blood pressure	no yes	Tuberculosis	no yes

Other serious illnesses which you have had and when _____

_____

Serious injuries or accidents and when _____

_____

DAILY HABITS

Do you regularly smoke? (circle) no yes If yes, how much? _____

Do you regularly drink 6 or more cups of coffee, cola tea per day? (circle) no yes

Do you regularly drink alcohol? (circle) no yes If yes, how much? _____ glasses/drinks per day

BLEEDING

Do you frequently have bleeding gums, bruising or nose bleeds? (circle) no yes

Have you had blood transfusions? (circle) no yes If yes, when? _____

MEDICATIONS

Which of the following medications do you presently take (check)?

__ Allergy medication
__ Antibiotics
__ Aspirin
__ Arthritis medicine
__ Barbituates
__ Birth control pills
__ Blood pressure pills
__ Blood-thinning pills
__ Cortisone or steroids
__ Dietary Aids
__ Digitalis
__ Dilantin
__ Diurectics (water pills)
__ Headache pills
__ Hormones
__ Insulin or diabetic pills
__ Iron-poor blood medicine
__ Laxatives
__ Shots
__ Sleeping pills
__ Thyroid medicine
__ Tranquilizers
__ Weight reducing pills
__ Other (list below)

Medications (prescription and non-prescription) that you have taken within the last month if not noted above:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Name any drugs to which you are allergic (including latex):

_____

FAMILY HISTORY

Do you know of any blood relative who has or had (check and give relationship):

__ Arthritis
__ Bleeding tendency
__ Breast cancer
__ Other cancer
__ Diabetes
__ Epilepsy
__ Heart attack
__ High blood pressure
__ High fever after surgery

SURGERY HISTORY

List the names and years of any operations or surgeries you have ever had:

_____

_____

Have you ever had any complications from anesthesia? (circle) no yes

If yes, explain _____

WOMEN ONLY

Is there any chance you may be pregnant? (circle) no yes

Are you still having regular monthly menstrual periods? (circle) no yes

Have you ever had discharge from your nipples? (circle) no yes

How many pregnancies? _____

Date of last pap smear __ __/__ __/__ __ Results_____

Date of last mammogram __ __/__ __/__ __ Results_____

Note: We recommend regular breast and pelvic exams by your regular physician or gynecologist

MEN ONLY

Is there a discharge from your penis? (circle) no yes

Have you ever had prostate trouble? (circle) no yes

The above information is true to the best of my knowledge.

_____ _____ Date __ __/__ __/__ __

Patient or responsible party's signature Witness' signature

Initial consent

PLEASE INITIAL WITHIN THE FOLLOWING BRACKETS AND SIGN BELOW

( ) I understand that I will be presented with a preliminary treatment plan and an estimate regarding the fees and costs associated with my treatment plan. I understand that these estimated fees and costs are an approximation, given by Dr. Vallecillos in good faith, and based upon his estimated evaluation of my condition. Dr. Vallecillos will explain to me that refinements or modifications to the treatment might become necessary; these changes will be discussed as, if, and when needed. I understand that confidential clinical pre-operative and post-operative photographs will be taken.

( ) Referrals made by Dr. Vallecillos and/or his office are made in good faith with the primary intent being the betterment of his patient. Thus, I am free and welcome to select a referral on my own. In no way is Dr. Vallecillos and/or his office responsible or liable as to the diagnosis, treatment, prognosis and/or financial responsibility of the referred healthcare provider.

( ) I understand that upon commencement of treatment with the selected plan, the total case fee (if for cosmetic purposes) is my responsibility. If the treatment plan is in part covered by insurance then an additional administrative fee (applied towards deductible and copay) is due prior to initiating treatment. This fee will be applied to the total procedural cost if the plan is carried through.

( ) Any dispute arising under this agreement or in connection with doctors services hereunder, including any claim by patient against doctor for malpractice of the tort claim, shall be resolved by binding arbitration in the County of Los Angeles, CA in accordance with the commercial arbitration rules of the American Arbitration Association. The prevailing party shall recover all collection and attorneys' fees.

( ) I give permission for photographs taken of me to be used for education, lectures and presentations of before and after treatments.

I HAVE READ AND UNDERSTOOD THE ABOVE AND AGREE TO ITS TERMS

Patient's signature _____ Date __ __/__ __/__ __