# PATIENT REGISTRATION

**Raad Taki, M.D.**
4580 E Camp Lowell Dr.
Tucson, AZ 85712
520-881-3232

☐ **Please Provide Photo ID**

_____
Patient's Last Name First Name Middle

_____-____-_____/___/_____
Social Security Number Date of Birth Email Address

_____
Address - Street, Apt # City/State Zip Code

_____
Primary Phone Number Mobile Phone Number Work Phone Number

_____
Employed By Occupation Employer's Address

_____
Nearest Relative or Friend Relationship to Patient Phone Number for Emergency

**Reason for Consultation:**

_____

**Referred By:**

_____

## HEALTH INFORMATION:

Height _____ Present Weight _____ Marital Status ☐ Married ☐ Single

Substance Use: Please disclose current or past substance abuse to the anesthesiologist prior to any procedure

Do you smoke Tobacco? ☐ Yes ☐ No If yes, how much and how often?_____

Do you smoke Marijuana? ☐ Yes ☐ No If yes, how much and how often?_____

Do you Vape? ☐ Yes ☐ No If yes, how much and how often?_____

Are you allergic to any medications? ☐ Yes ☐ No

Name of Medication and Type of Reaction: _____

_____

**LATEX ALLERGY?** ☐ Yes ☐ No Seasonal allergies? ☐ Yes ☐ No

Are you allergic to any foods or other substances? ☐ Yes ☐ No

Please list **all** medication you are now taking [including birth control pills, diuretics (water pills), blood pressure medication or ASPIRIN, IBUPROFEN (ADVIL), NAPROXEN (ALEVE)]. Please include implanted devices here (IUD, Pacemaker).

_____

# PATIENT REGISTRATION

**PREVIOUS SURGERY** (please list)

| Operation | Year | Complications, if any |
|---|---|---|
| | | |
| | | |

Have you ever had a REACTION to a GENERAL anesthetic? (Being put to sleep) ☐ Yes ☐ No

Have you ever had a REACTION to a LOCAL anesthetic? (Ex: Novocaine, etc.) ☐ Yes ☐ No

**SPECIFIC MEDICAL HISTORY:**

Have you ever had a problem with your heart? ☐ Yes ☐ No

- Do you have high blood pressure? ☐ Yes ☐ No
- Do you have fast or irregular heartbeats? ☐ Yes ☐ No
- Do you have dizziness or fainting spells? ☐ Yes ☐ No

Have you ever had a problem with your lungs? ☐ Yes ☐ No

- Asthma / Emphysema? ☐ Yes ☐ No
- Sleep Apnea? ☐ Yes ☐ No
- CPAP Machine? ☐ Yes ☐ No

Do you have stomach acid problems like Reflux (GERD/Heartburn)? ☐ Yes ☐ No

- Do you take reflux medicine or use antacids (Please list above) ☐ Yes ☐ No

Have you ever had any excessive bleeding problems? ☐ Yes ☐ No

Have you ever been diagnosed with or treated for blood clots? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No

Have you ever had a seizure? ☐ Yes ☐ No

Have you ever had psychiatric care? ☐ Yes ☐ No

Have you ever had a stroke, paralysis, vision loss, meningitis, or polio? ☐ Yes ☐ No

Have you seen other plastic surgeons about the SAME problem which brings you here? ☐ Yes ☐ No

Do you form heavy scars? ☐ Yes ☐ No

Do you have a personal or family history of breast cancer? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No Could you be pregnant now? ☐ Yes ☐ No

How many children do you have? _____

THE ABOVE MEDICAL HISTORY IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

Signature: _____ Date: _____/_____/_____

## Acknowledgement of Receipt of Privacy Health Information Practices

I have been presented with a copy of RAAD M. TAKI, M.D., P.C. **Notice of Privacy Health Information Practices** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medication information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to medical assignments of benefits apply.

**SIGNED:** _____ **DATE:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

**Relationship:** _____ **Witnessed by:** _____

_____

**Internal Use Only:**
If patient or patient's representative refuses to sign acknowledgment of receipt of notice, please document the date and time it was presented to patient and sign below.

**Presented on (date and time):** _____

**By (name and title):** _____

# COVID-19 INFORMED CONSENT AGREEMENT

☐ I, the undersigned patient, consent to an in-person consultation and/or to have Dr. Raad Taki and/or his staff perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand in-person consultations and/or having my procedure performed at this time, despite my own efforts and those of my doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

☐ I also understand in-person consultations and/or having my procedure performed at this time increases the risk of my transmission of COVID-19 to my doctor and/or staff. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my doctor's office, I accept that my doctor will implement infection-control procedures with which I must comply, before, during and after my consultation and/or procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

☐ I have informed my doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my doctor. I understand my doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my doctor, before I may receive my procedure.


☐ I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf, which website I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.

☐ All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my in-person consultation and/or procedure until the COVID-19 pandemic is less prevalent, but I choose to have my in-person consultation and/or procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

☐ _____ _____

*Patient/Authorized Representative Signature and Initials* Print Name & Date

The Aesthetic Society®

**Notice and Disclaimer.** Medical information changes constantly. This COVID-19 Informed Consent Agreement sets forth the current recommendations of The Aesthetic Society, is provided for informational purposes only, and does not establish a new standard of care. April 28, 2020