

## Jay Calvert, MD, FACS

465 N. Roxbury Drive, Suite 1001, Beverly Hills, CA 90210 ♦  400 Newport Center Drive, Suite 500, Newport Beach, CA 92660  
 Tel: (310) 777-8800 ♦ Tel: (949) 644-2858 ♦ Fax: (310) 861-1722

[www.drcalvert.com](http://www.drcalvert.com)

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Home Tel: (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Wk Tel: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Referring Physician: \_\_\_\_\_ SS# \_\_\_\_\_

How did you hear about Dr. Calvert? \_\_\_\_\_

Have you been to our website ([www.drcalvert.com](http://www.drcalvert.com))? \_\_\_\_\_ Was our website helpful? No Yes If No, pls. list reason: \_\_\_\_\_

What is the reason for your visit today? (Circle all applicable procedures below)

Nose & Face	Breast & Body	MediSpa
Primary Rhinoplasty	Breast Augmentation	Botox®
Revision Rhinoplasty	Breast Augmentation with Breast Lift	Restylane®
Brow Lift	Breast Reduction	Perlane®
Facelift	Capsulectomy	Juvéderm®
Neck Lift	Mommy Makeover	Radiesse®
Eyelid Surgery	Abdominoplasty	Enzyme Peel
Facial Implants	Post-Bariatric Body Lift	Laser Hair Removal
Chin Augmentation	Brachioplasty (Arm Tuck)	Skin Tightening Laser
Lip Augmentation	Liposuction	Photo Facial
Lip Suspension	Other _____	Pixel Treatment
Other _____	Other _____	Cellulite Treatment
Other _____	Other _____	Vein Treatment
Other _____	Other _____	Other _____

Please describe why you are interested in having the procedure(s) listed above: \_\_\_\_\_

\_\_\_\_\_

Have you consulted with other physicians about procedure(s) indicated above: No Yes

If Yes, please describe your understanding of the procedure(s) \_\_\_\_\_

Is this procedure a revision from a previous surgery No Yes If yes, how many previous surgeries?

\_\_\_\_\_

What is your "ideal time frame" for procedure(s) completion \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ B/P \_\_\_\_\_ (taken in office)

Employer \_\_\_\_\_ Address \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Primary Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Name of person insured \_\_\_\_\_ SS# \_\_\_\_\_

Eligibility Phone # \_\_\_\_\_ Copay \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Name of person insured \_\_\_\_\_ SS# \_\_\_\_\_

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### HEALTH INFORMATON

Eligibility Phone # \_\_\_\_\_ Copay \_\_\_\_\_

#### Personal Past History:

Do you have any chronic medical problems? (Circle all that apply)

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	
Emphysema		Chest Pain
Reflux	Stomach Problems	Gastric
	Asthma	Other _____

Is there a personal or family history of anesthetic complications?  No  Yes

If yes, please

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explain \_\_\_\_\_

#### Family History:

Do you have a family history of any medical problems? (Circle all that apply) Please indicate family member.

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	
Emphysema		Chest Pain
Reflux	Stomach Problems	Gastric
	Asthma	Other _____

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Please list all prior operations:

Date

List any complications

- |          |       |       |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

Please list all prior Hospitalizations:

Date

List any complications

- |          |       |       |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |

- 
5. \_\_\_\_\_

Please list ALL medications and/or dietary supplements including:

**(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)**

- |          |          |
|----------|----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |

- 
5. \_\_\_\_\_ 10. \_\_\_\_\_

Please list ALL allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc).

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |

- 
3. \_\_\_\_\_ 6. \_\_\_\_\_

Social History:

Have you ever used tobacco products? No Yes If yes, how long? \_\_\_\_\_ how much? \_\_\_\_\_

Which tobacco product(s) have you used? \_\_\_\_\_

If you are a former smoker, state the year you stopped: \_\_\_\_\_

Past or current use of Nicotine Gum, Patch, or any other type of stop-smoking aid: No Yes

If yes, please list: \_\_\_\_\_

Alcohol Consumption: \_\_\_\_\_ Never (Do not consume alcohol) \_\_\_\_\_ Rare (1-2 drinks a week)

\_\_\_\_\_ Moderate (7-10 drinks a week) \_\_\_\_\_ Heavy (daily or more than 10 drinks a wk)

Did you ever drink heavily in the past? No Yes

Are you feeling hopeless about the present/future? No Yes

Do you currently have thoughts of harming yourself? No Yes

### Review of Systems:

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

#### CARDIOVASCULAR

High Blood Pressure Y \_\_\_ N \_\_\_  
Heart Attack Y \_\_\_ N \_\_\_  
Angina/chest pain Y \_\_\_ N \_\_\_  
Heart bypass surgery Y \_\_\_ N \_\_\_  
Pacemaker Y \_\_\_ N \_\_\_

Heart Failure Y \_\_\_ N \_\_\_  
Irregular Heartbeat Y \_\_\_ N \_\_\_  
Heart Murmur Y \_\_\_ N \_\_\_  
Do you exercise? Y \_\_\_ N \_\_\_  
Comments: \_\_\_\_\_

#### NEUROLOGICAL

Stroke Y \_\_\_ N \_\_\_  
Seizures Y \_\_\_ N \_\_\_  
Fainting Y \_\_\_ N \_\_\_  
Dizziness Y \_\_\_ N \_\_\_  
Headache Y \_\_\_ N \_\_\_  
Double Vision Y \_\_\_ N \_\_\_

#### RESPIRATORY

Abnormal Chest X-ray Y \_\_\_ N \_\_\_  
Asthma Y \_\_\_ N \_\_\_  
Bronchitis Y \_\_\_ N \_\_\_  
Emphysema Y \_\_\_ N \_\_\_  
Recent Chest Infection Y \_\_\_ N \_\_\_  
Shortness of Breath Y \_\_\_ N \_\_\_  
Shortness of Breath at night Y \_\_\_ N \_\_\_  
Shortness of Breath on exertion Y \_\_\_ N \_\_\_  
Cough Y \_\_\_ N \_\_\_  
Cough with Sputum Y \_\_\_ N \_\_\_  
Sleep Apnea Y \_\_\_ N \_\_\_  
-Use a C-PAP Machine Y \_\_\_ N \_\_\_

#### PSYCHIATRIC

Depression Y \_\_\_ N \_\_\_  
Anxiety Y \_\_\_ N \_\_\_  
Psychiatric Care Y \_\_\_ N \_\_\_  
Obsessive Compulsive Disorder Y \_\_\_ N \_\_\_

#### MUSCULOSKELETAL

Sciatica Y \_\_\_ N \_\_\_  
Herniated disc Y \_\_\_ N \_\_\_  
Arthritis Y \_\_\_ N \_\_\_  
Rheumatoid Y \_\_\_ N \_\_\_  
Neck, Back, Arm, Leg Prob Y \_\_\_ N \_\_\_

#### ENDOCRINE

Diabetes Y \_\_\_ N \_\_\_  
Thyroid Disease Y \_\_\_ N \_\_\_  
Taken Steroids Y \_\_\_ N \_\_\_

#### HEMATOLOGIC/ONCOLOGIC/

Bleeding Tendency Y \_\_\_ N \_\_\_  
Easy Bruising Y \_\_\_ N \_\_\_  
Anemia Y \_\_\_ N \_\_\_  
Sickle Cell Disease Y \_\_\_ N \_\_\_  
Blood clots in legs Y \_\_\_ N \_\_\_  
Blood clots in lungs Y \_\_\_ N \_\_\_  
Radiation Therapy Y \_\_\_ N \_\_\_

#### INFECTIOUS

#### GASTROINTESTINAL

Jaundice Y \_\_\_ N \_\_\_  
Hepatitis Y \_\_\_ N \_\_\_  
Ulcers Y \_\_\_ N \_\_\_  
Hiatal Hernia Y \_\_\_ N \_\_\_  
Heartburn Y \_\_\_ N \_\_\_

#### URINARY/REPRODUCTIVE

Kidney Disease Y \_\_\_ N \_\_\_  
Urinary Disease Y \_\_\_ N \_\_\_  
Dialysis Y \_\_\_ N \_\_\_

#### SKIN

Basal cell skin cancer Y \_\_\_ N \_\_\_  
Melanoma Y \_\_\_ N \_\_\_  
Staph Infection Y \_\_\_ N \_\_\_

If Female, could you be preg? Y \_\_\_ N \_\_\_

Number of live births \_\_\_\_\_

Number of pregnancies \_\_\_\_\_

Date of last mammogram \_\_\_\_\_

Date of date of menses (period) \_\_\_\_\_

EYES

Cataracts

Glaucoma

Y \_\_\_ N \_\_\_

Y \_\_\_ N \_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to Jay Calvert, M.D., Professional Corporation, all Medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability be such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

# JAY W. CALVERT, M.D., F.A.C.S.

Certified by the American Board of Plastic Surgery

## PHOTOGRAPHIC RELEASE

**I HEREBY GIVE PERMISSION** to Dr. Jay Calvert and/or his Associate(s) or any assistant they may designate, to take photographs of me or my body parts in connection with the plastic surgery procedure(s) to be performed by Dr. Jay Calvert and/or for diagnostic purposes. I agree that these photographs will remain their property and a part of my permanent medical record. **(Initial here: \_\_\_\_\_)**

**I PROVIDE THIS AUTHORIZATION** as a voluntary contribution in the interests of patient education. I understand that such photographs shall become the property of Dr. Jay Calvert and may be retained by Dr. Jay Calvert or released by Dr. Jay Calvert for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to publication in medical journals and textbooks, physician photo books, physician website or for the purpose of informing the medical profession, the general public, or a patient about plastic surgery procedures and methods. **(Initial here: \_\_\_\_\_)**

**I FURTHER AUTHORIZE** them to use such photographs for teaching purposes. It is specifically understood that I shall not be identified by name. I understand that in some circumstances the photographs may portray features that will make my identity recognizable, even in instances where every effort is made to conceal my identity. **(Initial here: \_\_\_\_\_)**

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (“**HIPAA**”).

I release and discharge Dr. Jay Calvert and all parties acting under his license and authority from all rights that I may have to the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above authorization and release, and fully understand the terms.

Patient Printed Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_

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www.drcalvert.com

### Notice of Privacy Practices

#### **To our patients –**

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

#### **Our commitment to your privacy -**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

#### **Use and disclosure of your health information in certain special circumstances –**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement officer.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To a federal official for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

#### **Your rights regarding your health information –**

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychological notes. You must submit your request in writing to the Surgery Center.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to The Surgery Center. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Jay W. Calvert, M.D. / The Roxbury Clinic and Surgery Center (310-248-6250). All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for used and disclosures that are not identified by this notice or permitted by applicable law.

## Jay Calvert, MD, FACS

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## Notice of Privacy Practices

I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practices by Jay Calvert, MD, FACS.

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Name of Patient (Please Print)

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Signature of Patient

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Date

# Roxbury Clinic and Surgery Center

Dr. Calvert, Dr. Ordon, Dr. Brenner, Dr. Parsa and the Roxbury Clinic and Surgery Center are considered *out of network providers*, not in-network, for all insurance companies. We, as providers, are billing the insurance company solely as a courtesy to the patient. \_\_\_\_\_ initial

## SCHEDULING SURGERY

In order to schedule and reserve your date of surgery, the following is required:

- A 20% deposit (minimum of \$1000) must be paid.
- The balance and all applicable fees (cosmetic, insurance related deductibles and copays) will be due in full 3 weeks prior to the date of surgery.

## REVISIONAL PROCEDURE POLICY

Cosmetic surgery is real surgery and involves both risks and benefits associated with the surgical healing process. Healing varies from patient to patient and occasionally, a revisional (touch up) procedure may be necessary and beneficial.

The possible outcomes that may benefit from a touch-up include, but are not limited to, the following:

- Unfavorable scar
- Unfavorable shape, size and or contour
- Scar contracture (excess firmness)

We are committed to providing you with the best possible results that can reasonably be achieved for your particular surgical outcome.

If a touch-up procedure is advisable (as determined by the doctor) your cost will be limited to anesthesia and operating room fees. The fee will be determined by time in the operating room.

## CANCELLATION POLICY

- If you should cancel your surgery for any reason after it has been scheduled with less than ten working days notice, half (1/2) of surgeon fee will be nonrefundable to cover rescheduling costs, any contract labor, supplies and/or equipment that has been arranged for your case.
- If you cancel your procedure because we are unable to obtain medical clearance (i.e. you are not medically stable for surgery) or a similar reason, your payment will be refunded after review by our corporate office.
- If you reschedule your surgery more than once, we will charge a \$500 rescheduling fee.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date