Jay Calvert, MD, FACS

465 N. Roxbury Drive, Suite 1001, Beverly Hills, CA 90210 ◆ 1401 Avocado Ave., Suite 810, Newport Beach, CA 92660
Tel: (310) 777-8800 ◆ Tel: (949) 644-2858 ◆ Fax: (310) 861-1722
www.drcalvert.com

Date: ______________________________

Name: ____ Age: ____________ DOB: ______/______/______

Address: ________________________________ Home Tel: (______)______________________________

City ___________________________Zip________ Wk Tel: (______)______________________________

Email: __________________________________ Cell: (______)______________________________

Referring Physician: ______________________________ SS# ________________________________

In order to preserve your privacy in accordance with HIPAA rules, please check the boxes below which are acceptable ways you would like to have communication between you and our office.
Preferable methods of communication: ☐ email ☐ home phone ☐ cell phone ☐ work phone

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How did you hear about Dr. Calvert? ____

Have you been to our website (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# ____________________

Eligibility Phone # ____ Copay ______________________________________

HEALTH INFORMATON

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	Gastric Reflux	Stomach Problems
	Asthma	Other __________________

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

If yes, please 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	Gastric Reflux	Stomach Problems
	Asthma	Other __________________

Please list all prior operations:	Date	List any complications
1.______________________________________	___________________	______________________________
2. ______________________________________	___________________	______________________________
3. ______________________________________	___________________	______________________________
4. ______________________________________	___________________	______________________________
5. ______________________________________	___________________	______________________________

Please list all prior Hospitalizations: | Date | List any complications

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 ____

PSYCHIATRIC

Depression Y ___ N ____
Anxiety Y ___ N ____
Psychiatric Care Y ___ N ____
Obsessive Compulsive Disorder 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 ____

URINARY/REPRODUCTIVE

Kidney Disease Y ___ N ____
Urinary Disease Y ___ N ____
Dialysis 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)______________

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 ____

MUSCULOSKELETAL

Sciatica Y ___ N ____
Herniated disc Y ___ N ____
Arthritis Y ___ N ____
Rheumatoid Y ___ N ____
Neck, Back, Arm,Leg Prob Y ___ N ____

INFECTIOUS

GASTROINTESTINAL

Jaundice Y ___ N ____
Hepatitis Y ___ N ____
Ulcers Y ___ N ____
Hiatal Hernia Y ___ N ____
Heartburn Y ___ N ____

SKIN

Basal cell skin cancer Y ___ N ____
Melanoma Y ___ N ____
Staph Infection Y ___ N ____

EYES

Cataracts Y ___ N ____
Glaucoma 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