DR MOTYKIE
PLASTIC SURGERY

GARY MOTYKIE M.D.

Plastic and Reconstructive Surgery
9201 SUNSET BLVD., STE GF-1
WEST HOLLYWOOD, CA 90069
PHONE: 310.246.2355 FAX: 310.246.2365

PERSONAL INFORMATION

Patient Name: _____ **Date:** _____

Reason for Visit: _____ **Referred by:** _____

Date of Birth: _____ / _____ / _____ **Age:** _____ **Sex:** M / F **Marital Status:** Married/ Single/ Divorced

Social Security #: _____ **Driver's License #:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____ **Email:** _____

Home Phone #: (_____) _____ **Cell Phone #:** (_____) _____

Employer: _____ **Occupation:** _____ **Contact Phone #:** (_____) _____

Emergency Contact/ Relationship: _____ **Contact Phone #:** (_____) _____

INSURANCE INFORMATION

Subscriber Name: _____ **Relationship to Patient:** _____

Date of Birth: _____ / _____ / _____ **Age:** _____ **Sex:** M / F **Social Security Number:** _____

Address (if different): _____

Contact Phone #: (_____) _____ **Email:** _____

Insurance Co: _____ **Insurance Phone #:** (_____) _____

Policy #: _____ **Group #:** _____ **Subscriber #:** _____

ASSIGNMENT AND RELEASE

I authorize treatment of the individual named as Patient. I understand that Gary Motykie M.D. will file with my primary insurance for services rendered and I authorize payment of medical insurance benefits to be made to my treating physician. I also understand that I am financially responsible for any services that are not covered under the terms of my policy.

I authorize Gary Motykie M.D. to release or obtain any medical information related to its treatment of Patient. A photocopy of this authorization shall be considered as effective and valid as the original.

I fully understand and comply with this policy:

Signature of Patient or Responsible Party **Date**

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GUARDIAN INFORMATION

If patient is under the age of 18

Name: _____ **Date:** _____

Date of Birth: _____ / _____ / _____ **Age:** _____ **Sex:** M / F **Social Security #:** _____

Address (if different): _____

Contact Phone #: (_____) _____ **Email:** _____

Signature of Patient Guardian **Date**

PAST MEDICAL HISTORY

Prior Plastic Surgeries: _____

Past Medical Illness: _____

Are you currently being treated for any medical condition? (YES/ NO)

If yes, please list condition and treatment: _____

Medication Allergies: _____ **Easy Bruising or Bleeding: (YES/ NO)**

Personal Physician: _____ **Contact Phone #:** _____

Last Physical Exam Done By and the Date: _____

Ever Seen a Psychiatrist or Psychologist: (YES/ NO) **If YES, please list date:** _____

PATIENT HEALTH QUESTIONAIRE

Height: _____ **Weight:** _____ **Recent weight gain or loss?** _____

Smoking History: (YES/ NO) **If yes, please list daily amount:** _____

Drink Alcohol: (YES/ NO) **If yes, please list daily amount:** _____

Recent Chest X-Ray: (YES/ NO) **Comments:** _____

Recent EKG: (YES/ NO) **Comments:** _____

Recent Mammogram: (YES/ NO) **Comments:** _____

Signature of Patient, Parent or Guardian **Date**

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GUARANTOR INFORMATION

Person responsible for surgery/treatment fee

Name: _____ **Date:** _____

Date of Birth: _____ / _____ / _____ **Age:** _____ **Sex:** M / F **Social Security #:** _____

Address (if different): _____

Contact Phone #: (_____) _____ **Email:** _____

Employer: _____ **Occupation:** _____ **Contact Phone #:** (_____) _____

I, the undersigned, represent that all of the information on this form is true and complete to the best of my knowledge and belief and that I accept full financial responsibility for professional medical and surgical service rendered.

Signature of Patient or Responsible Party **Date**

Please check all of Dr. Motykie's surgical and Med Spa (non-surgical) services that are of interest to you:

Surgical Procedures

☐ Face, neck, brow lift	☐ Breast Augmentation
☐ Eyelid surgery	☐ Breast Revision/Reconstruction
☐ Nose surgery (cosmetic and breathing)	☐ Breast Lift
☐ Lip surgery	☐ Breast Reduction (both male and female)
☐ Facial Contouring, Implants, Fat Grafting	☐ Scar Revision
☐ Prominent Ear Reduction	☐ Liposuction
☐ Tummy Tuck	☐ Buttocks Enhancement
☐ Other	☐

Med Spa (Non-Surgical)

☐ Botox or Dysport Injections	☐ Medical grade facials or peels
☐ Dermal Fillers (Restylane, Juvederm, other)	☐ Anti-aging, prevention skincare
☐ CoolSculpting (non-surgical fat reduction)	☐ Eyelash enhancement
☐ Laser Hair Removal	☐ Nutrition and wellness
☐ Treatment to improve pigmentation/sunspots	☐ Massage and Reiki
☐ Skin tightening/firming	☐ Teeth whitening

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HEALTH QUESTIONAIRE CONTINUED

MEDICAL HISTORY	YES	NO
Heart attack, stroke, rheumatic fever		
High/low blood pressure		
History of chest pain		
Ankles swelling		
Shortness of breath		
Asthma		
Hives, rashes or skin disorders		
Fainting spells or seizes		
Diabetes		
Hepatitis, jaundice, cirrhosis		
Arthritis		
Kidney problems		
Tuberculosis or persistent cough		
Coughing up blood		
Venereal disease		
Emotional disorders		
Excessive bleeding in prior surgery		
Blood disorders or anemia		
Tumors of the mouth, nose, throat		

If YES to any of the above, please elaborate:

_____

_____

_____

_____

CURRENT MEDICATIONS	YES	NO
Antibiotics		
Blood Thinners		
Diet Pills		
Steroids, NSAIDS		
Aspirin, Motrin		
Insulin or Diabetic Medication		
Heart Medication		
Herbal Supplements		
Birth Control Pills		
Hormone Supplements		

If YES to any of the above, please give name and dose of medication:

_____

_____

_____

_____

ALLERGIES/ SENSITIVITIES	YES	NO
Local Anesthetics		
General Anesthetics		
Antibiotics (Penicillin)		
Barbiturates, Sedatives		
Morphine or Codeine		
Adhesive Tapes		
Latex		

_____

Signature of Patient, Parent or Guardian **Date**