# PATIENT REGISTRATION FORM

First Name: ________________________ Middle Initial: ____ Last Name: ____________________________

Address: ________________________________ Apt: ____City____________ State ______ ZIP:___________

Home Phone: (     )________________________ Email Address:____________________________________

Occupation: _____________________ Employer: _____________________ Work #: (     )______________

Date of Birth: _______________ Age: ________ Sex: M( ) F( ) Social Security # : _____________________

Driver's License number: ___________________________ Marital Status: S(  ) M(  ) W(  ) D(  )

Spouse's Name: ______________________________Spouse's Occupation: ____________________________

Spouse's Work # : (     )________________________

Closest relative other than Spouse: _____________________________ Phone: (     )_____________________

How did you first hear about our office? _________________________________________________________

May we thank the person that referred you to us? ☐ yes ☐ no

What improvements are you seeking?____________________________________________________________

What did you see, hear or feel that brings you to seek information at this time? ___________________________

___________________________________________________________________________________________

Have you discussed this with your: ☐ Spouse ☐ Family ☐ Friends
If so, their opinion was: ☐ Supportive ☐ Uncommitted ☐ Against It

Have you had a prior consultation with another doctor? ☐ Yes ☐ No

Have you had any other cosmetic surgery procedures? ☐ Yes ☐ No
If yes, please list: ______________________________________________________________________

What (if any) are your concerns about this procedure? _____________________________________________

When are you planning on having your procedure done? ____________________________________________

How will you pay for the services rendered? ☐ Cash ☐ M/C ☐ Visa ☐ Financing

**This information is accurate and true to the best of my knowledge.**

Signature_____________________________________________________ Date________________________

Your medical history is very important as it helps to alert us to any potential problems that might interfere with your surgery. Please take the time to fill this form out completely and accurately. The information will be kept confidential. If you need help, our staff can assist you.

Please print your NAME:_____________________________________________ Your AGE:________________

How is your general HEALTH?_________________________ Are you under a DOCTOR'S care?___________

List all MEDICATIONS you are currently taking:

PRESCRIPTION______________________________________________________________________________

NON PRESCRIPTION (aspirin, cold tablets, etc.)___________________________________________________

VITAMINS &/or HERBS _______________________________________________________________________

List all drugs to which you are ALLERGIC: ________________________________________________________

OTHER allergies (bee sting, food, etc.)__________________________________________________________

Do you SMOKE? _______________ If yes how much (per day, week)? ________________________________

Do you DRINK alcoholic beverages? ______________ If yes, how much? ______________________________

Have you used or do you now use recreational DRUGS? _________ If yes, list: ___________________________

Date of Last Menstruation: ____________________________________________________________________

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OPERATIONS/HOSPITALIZATIONS you have had:

____________________________________

____________________________________

____________________________________

____________________________________

Major ILLNESSES and INJURIES you have had:

____________________________________________

____________________________________________

____________________________________________

____________________________________________

Are you HIV positive?_____________ List any significant hereditary or infectious diseases in your family (i.e.

Diabetes, heart disease, TB, etc.): _____________________________________________________________

Has any BLOOD RELATIVE of yours ever had any problem with ANESTHESIA?________________________

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**HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS?**

| | | | | | |
|---|---|---|---|---|---|
| Glaucoma or blurry vision | (yes) | (no) | Recurrent severe dizziness | (yes) | (no) |
| Severe headaches | (yes) | (no) | Chronic sinus problems | (yes) | (no) |
| Asthma | (yes) | (no) | Shortness of breath | (yes) | (no) |
| Chest Pain | (yes) | (no) | Heart problems | (yes) | (no) |
| High Blood Pressure | (yes) | (no) | Rheumatic fever | (yes) | (no) |
| Recurrent abdominal problems | (yes) | (no) | Blood in bowel movements | (yes) | (no) |
| Kidney or bladder problems | (yes) | (no) | Blood in urine | (yes) | (no) |
| Bleeding disorder, easy bruising | (yes) | (no) | Seizures | (yes) | (no) |
| Pregnancies | (yes) | (no) | Menstrual disorder | (yes) | (no) |
| Abnormal lump or node | (yes) | (no) | Problems with bones or joints | (yes) | (no) |
| Hepatitis | (yes) | (no) | Tuberculosis | (yes) | (no) |
| Venereal disease | (yes) | (no) | Cancer | (yes) | (no) |
| Diabetes | (yes) | (no) | Chronic skin condition | (yes) | (no) |
| Emotional problems | (yes) | (no) | Psychiatric treatment | (yes) | (no) |
| Problems with anesthesia | (yes) | (no) | Complications after surgery | (yes) | (no) |
| A bad surgical result | (yes) | (no) | Unsatisfactory medical care | (yes) | (no) |
| Blood Clots | (yes) | (no) | | | |

Other:_______________________________________________________________________________

***IMPORTANT: Have you ever taken any type of diet medication?***__________________________________

Name of medication__________________________ When did you last take this medication?_______________

**THE PRECEEDING INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.**

| | |
|---|---|
| ______________________________ | ______________________________ |
| Patient signature | Date completed |
| ______________________________ | ______________________________ |
| Reviewed by | Date |
| ______________________________ | ______________________________ |
| Reviewed by | Date |
| ______________________________ | ______________________________ |
| Reviewed by | Date |
| ______________________________ | ______________________________ |
| Reviewed by | Date |

# Consent to Photograph

In connection with the medical services which I am receiving from Jan V. Karlin, M.D., I, the undersigned, do hereby authorize the above named surgeon to photograph or permit others to photograph________________________________________________________________
__________

Under the following conditions:

1) **The photographs may be taken only with the consent of my physician/surgeon and under such conditions and at such times as may be approved by him.**

2) **The photographs shall be taken by my physician/surgeon or by his assignee.**

3) These photographs shall be used for medical record only, unless in the judgment of my physician, medical research, education, promotion, and/or science will benefit from their use.

4) In the event the photos are used for medical research, education, promotion, and/or science, my identity will be omitted.

Patient Signature: _________________________________Date: __________

Parent if patient is a minor: _________________________Date: __________

Witness: ________________________________________ Date: __________

# Statement of Understanding

I agree that the determination of professional services to be rendered by my Doctor and the fees to compensate him for these services are matters concerning my Doctor and me. I understand that I have the primary duty and obligation to pay my Doctor for his services. Notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government or the like.)

Neither my Doctor nor I will permit any third party to determine what medical services I need or what fees the Doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our Doctor-Patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I as the Patient are in any way bound by any contract the other may have with any third party.

Patient: ______________________________ Date: ________________

Witness: _____________________________ Date: ________________

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ________________________________________________________

Signature: __________________________________________________________

Date: _____________________

# Jan V. Karlin, M.D.

Plastic and Reconstructive Surgeon/Phlebologist
7600 Dr. Phillips Boulevard, Suite 74
Orlando, Florida 32819
(407) 226-0609

**EDUCATION:** *Duke University School of Medicine,* Durham, North Carolina
Doctor of Medicine, 1970
*Harvard University,* Cambridge, Massachusetts
Bachelor of Arts in General Studies (Cum Laude), 1966
John Harvard Scholarship Recipient

**RESIDENCY:** *University of Illinois Hospital,* Chicago, Illinois
Chief Resident in Plastic Surgery, 1977-1978
Resident in Plastic Surgery, 1976-1977
Instructor in Plastic Surgery, 1977-1978
*Cedars-Sinai Hospital,* Los Angeles, California
Resident in General Surgery, 1974-1976
*Jackson Memorial Hospital,* Miami, Florida
Resident in General Surgery, 1973-1974
Intern in Straight Surgery, 1970-1971

**MILITARY:** *Lieutenant Commander,* USNR, 1974-1979
*Lieutenant, USN Medical Corps,* 1971-1973
*General Medical Officer,* Vietnam and San Diego

**LICENSES:** *Licensed to practice medicine in the following states:*
California, Florida, North Carolina, Illinois

***SOCIETY***
**MEMBERSHIPS:**
AMERICAN MEDICAL ASSOCIATION
FLORIDA MEDICAL ASSOCIATION
CALIFORNIA MEDICAL ASSOCIATION (FORMER MEMBER)
CANDIDATE MEMBER/AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS (FORMERMEMBER)
AMERICAN ACADEMY OF COSMETIC SURGERY
AMERICAN ACADEMY OF AESTHETIC MEDICINE
SOCIETY OF OFFICE BASED SURGERY
FLORIDA ACADEMY OF COSMETIC SURGERY
AMERICAN SOCIETY OF LIPOSUCTION
INTERNATIONAL SOCIETY OF PLASTIC, AESTHETIC AND RECONSTRUCTIVE SURGEONS (FORMER MEMBER)
EUROPEAN SOCIETY FOR COSMETIC AND AESTHETIC DERMATOLOGY
AMERCIAN COLLEGE OF PHLEBOLOGY
CANADIAN SOCIETY OF PHLEBOLOGY
VENOUS SOCIETY OF AMERICA
LASER INSTITUTE OF AMERICA
AMERICAN SOCIETY FOR LASER MEDICINE AND SURGERY, INC.
AMERICAN ACADEMY OF ANTI-AGING MEDICINE
GROWTH HORMONE RESEARCH SOCIETY

**CONTINUING MEDICAL EDUCATION:** Honored by the California Medical Association and American Medical Association for continued and ongoing attendance at all recent conferences and symposia on Plastic Surgery

**AUTHOR & MEDIA PERSONALITY:** Many authored articles in respected professional journals, numerous TV and Radio appearances including KZLA, KMAX, KGI, Eye on L.A., CNN, KTLA TV, NBC