TOOMARI SURGERY
ADVANCED MINIMALLY INVASIVE SURGERY

PATIENT PROFILE

IDENTIFYING INFORMATION REQUIRED

First Name	Middle Name	Last Name

Date of Birth (MM/DD/YYYY)	Social Security Number (XXX-XX-XXXX)	Height (Inches)	Weight (Pounds)	**Gender:** ☐ Male ☐ Female ☐ Other

Ethnicity: ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino ☐ Prefer not to say ☐ Other: _____

CONTACT INFORMATION REQUIRED

Mobile Phone	Email Address

Home Phone	Other Phone	Accept Text Messages? ☐ Yes ☐ No Translator needed? ☐ Yes Language: _____

Street Address	City	State	ZIP

EMERGENCY CONTACT REQUIRED

Name	Mobile Phone	Relationship

INSURANCE / PAYMENT REQUIRED

Primary Health Plan

Plan Name	Member ID	Group / Company Name	Effective Date (MM/DD/YYYY)

Guarantor (Name of Insured)	Guarantor's Date of Birth (MM/DD/YYYY)

Secondary Health Plan

Plan Name	Member ID	Group / Company Name	Effective Date (MM/DD/YYYY)

Guarantor (Name of Insured)	Guarantor's Date of Birth (MM/DD/YYYY)

ADVANCE DIRECTIVE & HEALTHCARE PROXY

Advance Directive / Living Will? ☐ Yes ☐ No	Healthcare Proxy? ☐ Yes ☐ No
Proxy Name	Proxy Phone

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YOUR PROVIDERS

Primary Care Physician	Phone	Fax

Cardiologist	Phone	Fax

Referring Physician	Phone	Fax

Preferred Pharmacy	Phone	Address

OCCUPATION

Occupation / Job Title	Physical demands:
	☐ Sedentary ☐ Light ☐ Moderate ☐ Heavy

HOW DID YOU HEAR ABOUT US?

☐ Another Physician ☐ Google ☐ Yelp ☐ Zocdoc ☐ Healthgrades ☐ Facebook/Instagram ☐ Our Website

☐ Friend/Family ☐ Insurance Directory ☐ AI/ChatGPT ☐ Intuitive Surgical ☐ Other: _____

PRIMARY REASON FOR TODAY'S VISIT — CHECK ONE REQUIRED

☐ Inguinal hernia ☐ Umbilical hernia ☐ Incisional hernia ☐ Diastasis recti ☐ Gallbladder/gallstones

☐ Acid reflux/hiatal hernia ☐ Diverticulitis ☐ Colon polyp/cancer ☐ Abdominal pain ☐ Other: _____

TREATMENT CONSENT & FINANCIAL AGREEMENT REQUIRED

By signing I consent to evaluation, examination, and treatment by Dr. Nojan Toomari DO FACS, Toomari Surgery, Nojan Toomari DO Inc, and/or other qualified medical practitioners. I am financially responsible for all charges not covered by my insurance. Co-pays and deductibles are due at time of service. Elective procedures require full payment 2 weeks prior to surgery. Refunds are not automatic — contact our office if one is owed after insurance processes. I consent to a headshot photo being stored in my medical chart for identification. I consent to telemedicine visits and AI-assisted documentation. I shall notify staff in writing prior to visit to decline.

IMPORTANT: Toomari Surgery is a separate entity from the hospital, surgery center, anesthesia group, and all other treating providers. We have no affiliation with, control over, or responsibility for their billing, charges, or insurance estimates. Patients receive separate bills from those entities and Toomari Surgery cannot be held responsible for their invoices.

Patient or Guardian Signature	Date
Click to sign	

Print Name

MEDICAL HISTORY

★ **REQUIRED** — Complete all fields. If none apply, check the 'None' box.

Today's Date	Patient First Name	Last Name

PREVIOUS SURGERIES REQUIRED

☐ **No prior surgeries**

Surgery / Procedure	Date	Hospital / Facility	Abd/Pelvic?	Mesh used?

MEDICAL CONDITIONS — CHECK ALL THAT APPLY REQUIRED

☐ **None of the following** ☐ High blood pressure ☐ High cholesterol ☐ Sleep apnea ☐ COPD/Asthma

☐ Diabetes ☐ Heart disease/CAD ☐ Kidney disease ☐ Liver disease/cirrhosis ☐ Blood clot/DVT/PE ☐ Bleeding

☐ Thyroid disease ☐ Anxiety/depression/psychiatric medication ☐ Cancer — type: _____ ☐ Other: _____

FEMALE PATIENTS

Pregnancies: _____ Vaginal: _____ C-sections: _____

Future pregnancy plans? ☐ Yes ☐ No ☐ Unsure

MALE PATIENTS

☐ BPH / urinary hesitancy or frequency

☐ Prior prostate or pelvic surgery

MEDICATION ALLERGIES REQUIRED

☐ **No known drug allergies** ☐ **LATEX Allergy**

Medication / Substance	Reaction

CURRENT MEDICATIONS REQUIRED

☐ No current medications

Medication	Dose (mg)	Frequency	Start Date

FAMILY HISTORY

☐ No significant family history

☐ ADOPTED

Family Member	Current Medical Conditions	If Deceased — Cause & Age
Mother		
Father		

Surgical Safety, Social History & Review of Systems

★ REQUIRED — Complete all fields. If none apply, check the 'None' box.

SURGICAL SAFETY — FLAGGED MEDICATIONS REQUIRED

☐ No blood thinners ☐ No anticoagulants	If yes:	Medication:	Last dose (MM/DD/YYYY):
☐ No GLP-1 medication: Ozempic, Wegovy, Mounjaro, Zepbound	If yes:	Medication:	Last dose (MM/DD/YYYY):
☐ No Daily Aspirin ☐ No Daily NSAIDs: Advil, Aleve, Excedrin	If yes:	Medication:	Dose Used:

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ANESTHESIA HISTORY REQUIRED

☐ **No prior general anesthesia** | If prior — complications? ☐ None ☐ Difficult intubation ☐ Severe nausea/vomiting

☐ Prolonged wake-up ☐ Malignant hyperthermia ☐ Other: _____ Family history of complications: ☐ Yes ☐ No

IMPLANTED CARDIAC DEVICE REQUIRED

☐ **None** | ☐ Pacemaker ☐ ICD (defibrillator) ☐ Other: _____ Implanted by: _____

BLEEDING & WOUND HISTORY REQUIRED

☐ **No history of problems** | Abnormal bleeding or clotting: ☐ Yes ☐ No Describe: _____

☐ Prior wound infection ☐ Dehiscence ☐ Hernia at incision site

SLEEP APNEA REQUIRED

☐ **No sleep apnea** | ☐ Diagnosed sleep apnea → ☐ On CPAP ☐ Not on CPAP

SOCIAL HISTORY REQUIRED

Tobacco (cigarettes, cigars, pipe): ☐ No ☐ Yes packs/ day & years smoked: _____ or quit year:_____

Vaping / e-cigarettes: ☐ No ☐ Yes frequency: _____

Alcohol: ☐ No ☐ Yes drinks per week: _____

Marijuana/THC (any form): ☐ No ☐ Yes: _____

Recreational drug use: ☐ No ☐ Yes: _____

History of substance abuse / addiction treatment: ☐ No ☐ Yes details: _____

REVIEW OF SYSTEMS — CHECK ANY EXPERIENCED IN THE PAST 12 MONTHS REQUIRED

Gastrointestinal

☐ Nausea/vomiting
☐ Acid reflux/GERD
☐ Difficulty swallowing
☐ Peptic ulcers
☐ Diarrhea
☐ Constipation
☐ Change in bowel habits
☐ Abdominal pain
☐ Blood or tarry stools
☐ IBD (Crohn's/UC)
☐ IBS
☐ Gallbladder pain

Musculoskeletal

☐ Joint pain / Arthritis

Genitourinary

☐ Blood in urine
☐ Frequent UTIs
☐ Kidney stones
☐ BPH / urinary hesitancy
☐ Prior prostate or pelvic surgery

Endocrine / Metabolic

☐ Diabetes
☐ Thyroid disease
☐ Unexplained weight change

Cardiac

☐ Chest pain / Palpitations
☐ Shortness of breath on exertion
☐ High blood pressure
☐ Stroke or TIA

Pulmonary

☐ Shortness of breath at rest
☐ Asthma or COPD
☐ Coughing up blood

Constitutional

☐ Fever or chills
☐ Unexplained fatigue

Vascular

☐ Leg pain or swelling
☐ History of DVT or pulmonary embolism

Psychiatric

☐ Anxiety
☐ Psychiatric medication

Additional comments:

_____

HIPAA · AI-Assisted Documentation · Telemedicine Consent · Media

HIPAA PRIVACY NOTICE REQUIRED

The Health Insurance Portability and Accountability Act (HIPAA) and the California Confidentiality of Medical Information Act (CMIA) protect your health information. Full details are available in our office or at www.hhs.gov. Your Protected Health Information (PHI) will be kept confidential except as necessary to provide care, including sharing with other healthcare providers, laboratories, and insurance payers. Your information will never be sold. Our Electronic Medical Record (EMR) is secure and encrypted. De-identified data may be used in retrospective studies. Studies requiring personal identifiers require separate written consent. We may contact you by phone, email, text, or mail for appointment reminders and practice updates. You have the right to request restrictions on the use of your PHI to the extent permitted by law.

AI-ASSISTED MEDICAL DOCUMENTATION CONSENT REQUIRED

Toomari Surgery uses AI-powered transcription technology during clinical encounters, including in-person and telemedicine visits. This technology listens to and transcribes the spoken conversation between you and your provider to assist with clinical documentation. By signing below you acknowledge and agree to the following: • **Audio Recording:** Your conversation may be recorded, transcribed, and/or analyzed by AI software solely for clinical documentation. Audio is deleted per our data retention policy. • **California Law:** This consent satisfies the CMIA (Cal. Health & Safety Code §§56–56.37) and California Penal Code §632 (two-party consent). Your signature constitutes your informed consent to this recording. • **HIPAA Compliance:** AI scribe vendors are bound by Business Associate Agreements (BAAs) ensuring your PHI is protected. • **No Marketing:** Transcription data will not be used for commercial purposes, sold to third parties, or used for AI training without separate written consent. • **How to Decline:** Notify staff IN WRITING before your encounter begins to decline AI scribe use. Consent is assumed unless written notice is received. Declining will not affect your access to care. • **Vendor Flexibility:** We may use different HIPAA-compliant AI platforms (e.g., Doximity, Zoom AI) from time to time. This consent applies to any such platform used during your care.

TELEMEDICINE CONSENT REQUIRED

Toomari Surgery offers video and telephone visits as an alternative or supplement to in-person care. By signing below you understand and agree to the following: • **Technology Risks:** Telemedicine uses electronic communication which may have technical limitations or interruptions. Encrypted platforms will be used to the extent practicable. • **Limitations:** Telemedicine may not be appropriate for all conditions. In an emergency, call 911. • **Privacy:** Please conduct your telemedicine visit in a private location. AI documentation tools may also be active during telemedicine encounters (see above). • **California Compliance:** Services provided per California B&P Code §§2290.5 and applicable telehealth regulations. • **Right to Refuse:** Participation in telemedicine is voluntary. You may request an in-person visit at any time.

By signing below I acknowledge that I have received and read this notice of Healthcare Privacy Practices, AI Documentation Consent, and Telemedicine Consent, and agree to the guidelines set forth above. I understand that I may revoke this consent in writing at any time. This consent complies with HIPAA, CMIA, and California Penal Code §632.

Patient or Guardian — HIPAA / AI Scribe / Telemedicine	Date (MM/DD/YYYY):
Click to sign	
Print Name	

AUTHORIZATION TO RELEASE & USE IMAGES AND HEALTH INFORMATION

I hereby grant permission to Nojan Toomari, DO Inc. for all images of me — photographs, film, or videotape, in print, electronic, video, and broadcast formats — to be taken and used by Nojan Toomari, DO Inc., its staff, representatives, or media, in addition to the use of my name, comments, and endorsements, including but not limited to all printed and digital publications, for education, communicating events, programs, procedures, promotional materials, publications, marketing efforts, productions and the like, without restriction. I agree that Nojan Toomari, DO Inc. may use, edit, and reproduce these images in any form, and may share them with other media for promotional and marketing purposes. Once released, Nojan Toomari, DO Inc. retains no further control over their use. I release all claims against Nojan Toomari, DO Inc. and other media with respect to copyright, publication, or use of such photographs or video footage, including any claims for compensation. Any photograph using my likeness will be the property of Nojan Toomari, DO Inc. and will not be returned. I irrevocably authorize Nojan Toomari, DO Inc. to edit, alter, copy, exhibit, publish, or distribute photos of me for purposes of publicizing its services and programs or for any other lawful purpose. I waive the right to inspect or approve the finished product and waive any right to royalties or compensation. I acknowledge that my participation is voluntary and that I have not been promised nor will I receive any financial compensation. I further authorize release my protected health information regarding my medical condition or treatment to its staff, representatives, or media outlets for news stories or other communications (TV, radio, newspaper, magazines, websites, video, news releases, or promotional materials). I am at least 18 years of age and am competent to contract in my own name. I have read this release before signing and fully understand the contents, meaning, and impact. NOTICE: Nojan Toomari, DO Inc. is required by law to keep your health information confidential. You are NOT required to sign this to receive treatment, payment of care, health plan enrollment, or eligibility for benefits.

Patient or Guardian — Media Authorization Signature	Date (MM/DD/YYYY):
Click to sign	
Print Name	

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Submit Your Completed Forms

Thank you for completing your new patient paperwork.

Please review all pages to confirm every field is complete and all signatures and dates have been entered. Then submit using one of the methods below.

REQUIRED — SUBMIT BEFORE YOUR APPOINTMENT REQUIRED

☐ **Insurance card(s)** — Front AND back, both primary and secondary if applicable

☐ **Photo ID** — Government-issued, front

☐ **Patient identification photo** — Clear headshot/selfie for your medical chart

HOW TO SUBMIT

Email: **records@toomarisurgery.com** (please attach the completed document and include your full name and date of birth)

Text photos: **818.570.1844** (insurance cards, photo ID, headshot)

Fax: **818.860.1845** (include your full name and date of birth on all pages)

In Person: Bring the completed, signed packet to your appointment at 16661 Ventura Blvd., Suite 408, Encino, CA 91436.

OUTSIDE RECORDS — SEND IF AVAILABLE (NOT REQUIRED BUT VERY HELPFUL)

☐ **No outside records**

☐ CT scan ☐ Ultrasound ☐ MRI ☐ EGD ☐ Colonoscopy report ☐ Pathology report ☐ Prior operative report

☐ Other imaging

Records can also be faxed to **818.860.1845** — please include your full name and date of birth.

Questions? Call **818.570.1845** — our front desk is happy to help with anything on this packet.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

CMS Open Payments: https://openpaymentsdata.cms.gov

Email Completed Form