

PATIENT INFORMATION

(Please Print)

Date: _____

Patient: _____
Last First M.I.

Responsible Party (if patient is a minor): _____

Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Social Security #: _____

Sex: M F Age: _____ Birthdate: _____ Single Married Divorced / Separated

Email: _____

(For monthly specials, and practice information only! We do not sell our email lists to anyone, ever).

Reason for Visit: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Spouse's Name (if applicable): _____

Spouse's Social Security #: _____

Employed By: _____

Business Address: _____

Occupation: _____ Business Phone: _____

In Case of Emergency, Contact: _____ Phone: _____

Any Allergies?: _____

How did you hear about us?: _____

(Authorized Signature of Patient or Responsible Party)

(Date)

Patient Health History

Name: _____ Birthdate _____ Age: _____

Primary Care Doctor: _____ Reason for Visit: _____

List Medical Problems or Illnesses: _____

List previous surgeries (including cosmetic surgery): _____

List any medications you are taking, including vitamins or herbal medicines: _____

Past Medical History

Have you ever had any of the following? (Please circle the appropriate response)

Heart Disease	Yes / No	HIV or AIDS	Yes / No	Joint Replacement	Yes / No
Lung Disease	Yes / No	Hepatitis	Yes / No	Bleeding Tendency	Yes / No
Diabetes	Yes / No	Stroke	Yes / No	Skin Cancer	Yes / No
High Blood Pressure	Yes / No	Stomach Problems	Yes / No	Arthritis	Yes / No
Asthma	Yes / No	Mitral Valve Prolapse	Yes / No	Thyroid Disease	Yes / No
Blood Clots in Legs	Yes / No	Glaucoma	Yes / No	Kidney Disease	Yes / No

Family History

Have you or any of your relatives had any of the following? (Please circle the appropriate answer)

Breast Cancer	Yes / No	Diabetes	Yes / No	Cancer	Yes / No
Melanoma	Yes / No	Kidney Disease	Yes / No	If so, what kind?	_____
Heart Disease	Yes / No	Stroke	Yes / No	Any other?	_____
High Blood Pressure	Yes / No	Depression	Yes / No		

Social History

Job Description: _____

Do you or did you ever smoke cigarettes? **Yes / No** If so, how many packs per day? _____ When did you quit? _____
Alcohol Use? **Yes / No** # Of Alcoholic drinks per week? _____
Recreational Drug Use? **Yes / No** What Kind? _____

Review of Symptoms

Have you had any of the below listed symptoms in the past year?

Fever & Chills	Yes / No	Swollen Feet	Yes / No	Swollen Lymph Nodes	Yes / No
Skin Lesions/Rash	Yes / No	Body Piercing	Yes / No	Joint Pain	Yes / No
Headache	Yes / No	Weight Change	Yes / No	Muscle Pain	Yes / No
Dry Eyes	Yes / No	Abdominal Pain	Yes / No	Dentures	Yes / No
Ear Infection	Yes / No	Chronic Cough	Yes / No	Wear Contacts	Yes / No
Sinusitis	Yes / No	Chest Pain	Yes / No	Easy Bruising	Yes / No
Wheezing	Yes / No	Sore Throat	Yes / No	Easy Bleeding	Yes / No
Urinary Infection	Yes / No	Taken Steroids	Yes / No	Anxiety	Yes / No
Depression	Yes / No	Seizures	Yes / No		
Tattoos	Yes / No	Jaundice	Yes / No		
Diarrhea	Yes / No	Breast Lump	Yes / No		

Women Only

Number of Pregnancies _____ Date of last menstrual period _____
Number of children _____ Date of last Mammogram _____ Results _____
Did you breast feed? _____ Do you perform regular self examinations on your breasts? _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____

FINANCIAL POLICY – CASH PATIENT

Las Vegas Plastic Surgery charges a small fee for initial cosmetic surgery consultation.

If the consultation is not an initial consultation a \$180 fee will apply. Examples include, but are not limited to; Treatment or second surgical opinion on a cosmetic procedure not performed by Dr. Roth. (i.e.; previous breast augmentation). Previous consultation with Dr. Roth, and you desire a second consultation. Breast Reduction. Additional fees may apply for attorney reports, IME's, or disability reports.

Once you have had your consultation and you decide to schedule surgery, our office will collect a \$500 non-refundable surgery scheduling fee.* This deposit will apply towards your surgery, it is non-refundable, and if you decide to cancel your surgery the monies will not be refunded and **cannot** applied towards any other services offered at Las Vegas Plastic Surgery. The balance due for your surgery will be collected at your pre-op appointment. If you reschedule your surgery, the deposit still applies toward that surgery. The methods of payment that we accept are: Cash, Cashier's Checks, Visa, Mastercard, Discover, American Express, and Personal Checks with guarantee card. If you are going for pay for your surgery with a personal check, arrangements will be made for you to pay two (2) weeks prior to your surgery.

If you are going through a finance company, (i.e. Care Credit, MediCredit, Capital One, etc.), a surgery deposit is not required, as they will pay the office in full one week prior to surgery.

If you are having Botox, Restylane, Perlane, Collagen, Juvaderm, Microdermabrasion, or if you are purchasing products today, you will be expected to pay at the end of the visit. Please ask for a receipt if you do not receive one. If you have any questions (we love questions) please do not hesitate to ask. We desire to make your experience the best as possible.

*Medicredit Patients do not require a surgery scheduling deposit.

(Patient's Signature)

(Date)

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Procedure: _____

I consent to be photographed or imaged by computer before, during and after my treatment. This release includes the following photographs taken by Dr. Jeffrey J. Roth or his designated associates.

Neither I, nor any member of my family, will be identified by name in any publication. Although Las Vegas Plastic Surgery will do everything to protect anonymity, I understand that in some circumstances, the photographs may portray features that will make my identity recognizable.

Dr. Roth **CAN** use my photographs or images in one or more of the following:
(Please initial or check)

_____ Patient Office Preview Albums

_____ Website

_____ Lectures or Presentations to Physician's Groups

_____ Lectures or Presentations to the Public

_____ Medical Journals or Textbooks

_____ Advertisement Purposes (Newspapers, Magazines, Television and /or Brochures)

I release and discharge Dr. Jeffrey J. Roth from all rights that I may have in photographs and from any claim that I may have relating to such use and publication which may include any claim for payment in connection with distribution of publication of photographs.

I grant this consent as a voluntary contribution in the interest of medical and public education about plastic surgery methods. I also certify that I have read the above authorization and fully understand its terms.

Patient Signature

Date

Patient Name (Please Print)

Witness