

PATIENT INFORMATION
(Please Print)

Date: _____

Patient: _____
Last First M.I.

Responsible Party (if patient is a minor): _____

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): _____

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 your 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 _____

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 / Social Media
- _____ 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

FINANCIAL POLICIES / OVERVIEW

REGISTRATION

- We request basic information for our administrative records and provide you with an overview of the consultation process. Cosmetic and initial Scar Revision consultations are complimentary, although additional fees may apply for attorney reports, IME's, or disability reports.

SURGEON CONFERENCE

Dr. Roth will talk with you about your wishes and desires. He will examine you and give you his opinion about how to achieve your goals. We believe you need to be well-informed about the actual process of preparing for, and recovering from, cosmetic or reconstructive surgery.

- Choosing a surgeon is an intensely personal decision. We encourage you to take time to ask the doctor and his staff any questions you may have. We believe the formation of a personal bond is an integral part of the surgery and healing process.

SKINCARE & INJECTABLES

- If you are having any Injectables, Fillers or Skin Care Treatments, or if you are purchasing products today, payment is expected at the end of the visit. If you have any questions (we love questions) please do not hesitate to ask. We desire to make your experience the best as possible.

EDUCATION

- You may choose to look at a video about the procedure(s) you are contemplating. Brochures are also available, which you may read and/or take home.

COST/TIMING

- When you meet with our Patient Coordinator, she will answer your questions and review the surgical fees. We will do our best to accommodate your schedule if you have a specific date in mind. After your consultation you or your family may have additional questions and we are happy to schedule a second consultation to review your surgical goals.

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 be applied towards any other services offered at Las Vegas Plastic Surgery.

The balance due for your surgery will be collected at your PREOPERATIVE 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, Care Credit, Visa, MasterCard, Discover, American Express - we do not accept any Personal Checks. All forms of payment for any service or treatment must be accompanied by a receipt. If you are not offered a receipt please inquire and it will be provided immediately.

INSURANCE

- Because we are a primarily cosmetic surgery practice, we are not providers under any insurance plans nor providers under Medicare, Medicaid, Worker's Compensation or any private healthcare networks. Payment for all surgery is the sole responsibility of the patient and full payment is required in advance.

Patient Signature: _____ Date: _____