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).

[ ] Check box if you consent to PMI (personal medical information) being sent via TXT / SMS. This will enable us to text you important information other than just appointment details.

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)

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American Board of Plastic Surgery

Jeffrey J. Roth, M.D., F.A.C.S.
plastic surgery

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 ________

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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

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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: ____________