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 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 ________

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