

Patient Registration

Date: _____ *Account #: _____

Referred By: _____

Would you like to be added to our mailing list? Yes _____ No Thanks _____

Patient's Full Name: _____

S.S. #: _____ DOB: _____ Age: _____ Circle One: F M

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax No.: _____

Email Address: _____ D.L. No.: _____

Mailing Address: _____

City: _____ St: _____ Zip: _____

Employment: (if minor, responsible parties)

Employed By: _____

Position: _____ May we call you at work? _____

Address: _____

Marital Status:

Circle one: Married Single Separated Divorced Widowed

Spouse's Name: _____ S.S. #: _____

Spouse's Employer: _____ Phone #: _____

Address: _____

In case of emergency:

Name: _____

Relationship: _____ Phone #: _____

Second Contact: _____

Relationship: _____ Phone #: _____

I understand that I am financially responsible for all charges. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, money orders and all major credit cards.

Signed: _____

Health History Form

Dr. _____

Name					Date
Address					
D.O.B.	Age	Height	Weight	Home Phone	Work Phone
Reason for visit today?					

Past/Current Hx (Check all applicable)

<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Asthma	<input type="checkbox"/> Neck Problems	<input type="checkbox"/> Fever Blisters
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Abnormal or Excessive Bleeding
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> HIV	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Taken Accutane with in Past Year
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures	<input type="checkbox"/> Keloids	

Other Major Illnesses:

Medications:	Reason for Taking	Frequency/Dose

Do you take ANY Diet Pills, Natural Herbs or Health Food Supplements? If Yes, What: _____

Allergies and Reactions to Medication? _____

Previous Surgeries: _____

Have you or anyone in your family had complications from Anesthesia? If Yes, please explain: _____

Have you been on ANY steroids in the last year? If Yes, please explain: _____

Do you take aspirin on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use any Tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have excessive bleeding or bruising? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any teeth that are: <input type="checkbox"/> Loose <input type="checkbox"/> Fragile <input type="checkbox"/> Capped <input type="checkbox"/> False	

Signature	Date
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Insurance Information

Account # _____
* office use only

Patient Name: _____ Male _____ Female _____

DOB _____ Age _____ S.S.# _____

Primary

Insurance _____

Insured _____ S.S.#: _____

Sex: Female _____ Male _____ DOB: _____ Relation to Patient _____

Ins. Claims Address _____

Pre-Certification Phone # _____

Policy #: _____ Group #: _____

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Secondary

Insurance _____

Insured _____ S.S.#: _____

Sex: Female _____ Male _____ DOB: _____ Relation to Patient _____

Ins. Claims Address _____

Pre-Certification Phone # _____

Policy #: _____ Group #: _____

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Assignment Of Benefits: I hereby assign all medical and / or surgical benefits for private insurance (Not to include Medicare, unless specific arrangements have been made) to: Dallas Plastic Surgery Institute. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.

Signed: _____

Dr. _____ Date: _____



SAM JEJURIKAR, MD

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PHOTOGRAPHIC AUTHORIZATION AND RELEASE

By my signature below, I authorize Sam Jejurikar, MD, and his employees or agents to photograph me and/or make electronic recordings of me (hereafter referred to as photographic or electronic reproductions) in connection with the plastic surgery procedure(s) he has performed or may perform. This consent includes the taking of photographic or electronic reproductions of any part of my body.

I authorize the use of any such photographic or electronic reproductions of me for purposes of my treatment, education endeavors, and quality assurance review. I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing and/or other imaging records created in my case, for the use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. To the extent that I am not identifiable from such photographic or electronic reproductions, they may be used for any purpose, including but not limited to scientific or education purposes or publication in newspaper, magazines, and other public media as may be deemed appropriate by Sam Jejurikar, MD.

I understand that I may refuse to consent to the taking of any photographic or electronic reproductions that are not intrinsic to my operation or procedure without prejudice to my care.

Neither I, nor any member of my family, will be identified by name in any form of publication. Wherever possible, the photos will be cropped so as to show only the pertinent information, but not personally identifying information. I understand that in some circumstances, the photographs may portray features that will make my identity recognizable.

I have entered into this agreement in order to assist scientific treatment, educational, public relations and/or charitable goals and hereby waive any right for compensation for these uses. I and my successors and assignees hereby waive any right for compensation for these uses. I and my successors and assignees hereby hold Sam Jejurikar, MD, his employees, and any other person participating in my case and their successors and assignees harmless against any claim for injury or compensations resulting from the activities authorized by this consent.

Patient Printed Name

Witness Printed Name

Patient Signature

Witness Signature

Date

Time