Patient Registration

#7

Account No. (Office Use Only)	
Referred By	Date

How did you hear about us?

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

Patient

Full Name			
Social Security No.	D.O.B.	Age	☐ Male ☐ Female
Home Phone	Work Phone	Fax Phone	
Cell Phone	Preferred Phone	Pharmacy Phone	
Email Address		Drivers License No.	
Mailing Address			
City, State, Zip			

Employment (if minor, responsible parties)

Employed By	
Position	May we call you at work? ☐ Yes ☐ No
Address	

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name	Social Security No.
Spouse's Employer	Phone No.
Address	

In Case of Emergency

Name	Relationship	Phone No.
Name	Relationship	Phone No.

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 most major credit cards.

Signature _____ Date _____

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)

☐ Lung Disease	☐ High Blood Pressure	☐ Asthma	☐ Keloids	☐ Abnormal or Excessive Bleeding
☐ Liver Disease	☐ Mitral Valve Prolapse	☐ Hepatitis	☐ MRSA	☐ Taken Accutane with in Past Year
☐ Kidney Disease	☐ Chest Pain	☐ HIV	☐ Fever Blisters	☐ Neck Problems
☐ Heart Disease	☐ Diabetes	☐ Seizures	☐ Dry Eyes	☐ Sleep Apnea
				☐ Use CPAP/BPAP

Other Major Illnesses:

Medications:

Name	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: _____

_____

_____

Has anyone in your family had breast cancer before the age of 50? If Yes, please explain: _____

_____

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

_____

Do you take asprin on a regular basis? ☐ Yes ☐ No

Do you have excessive bleeding or bruising? ☐ Yes ☐ No

Do you use any Tobacco products? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you have any teeth that are: ☐ Loose ☐ Fragile ☐ Capped ☐ False

Signature	Date

SURGERY SCHEDULING AGREEMENT

Your decision to schedule surgery with our office is very important to us. When you choose a surgery date, we are committing a block of Dr. Rohrich's time as well as the time it takes his office staff to coordinate with the anesthesiologist and the operating room/staff.

DEPOSIT

When you are ready to schedule, we will collect a $1,000 deposit in order to secure your surgery date. This deposit is **not refundable**, but will be reapplied to a new surgery date for up to one year from the original date of surgery should you need to reschedule. We also require a $250 deposit if you are required to stay at the Cloister Hotel.

CANCELLATION OF SURGERY

Cancellation of your surgery will result in forfeiture of your $1,000 deposit. The $1,000 cannot be used towards any other in-office services or procedures. Any cancellation of surgery in the operating room and/or hotel with less than 10 business days of surgery will result in a cancellation fee of $250 payable to Dallas Day Surgery Center and $250 payable to the Cloister Hotel.

RESCHEDULING YOUR SURGERY

First Reschedule – We understand that there are unforeseen circumstances that arise that may cause the need to reschedule your surgery, therefore, there will be no charge for the first reschedule.

Second Reschedule – A $250.00 service fee will be charged for rescheduling the second time. This is a service fee and will not apply towards your surgical fees and will not be refunded.

Third Reschedule – Payment will be due in full for all surgery fees - Dr. Rohrich's surgical fee, anesthesia fee, operating room, and hotel fee (if applicable) before rescheduling a new date.

PAYMENT DUE DATE

The balance of your surgery fee is due in full 3 weeks prior to surgery. If payment is not received on your due date, your surgery date will be released.

By signing this agreement, I acknowledge that I have read and understand the statements contained herein.

_____ _____

Patient (Print Name) Date

_____

Signature of Patient

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DALLAS PLASTIC SURGERY INSTITUTE
ROD J. ROHRICH, M.D.

Pt. Name: _____

Address: _____

_____

City State Zip

DOB: _____

SSN: XXX-XX-_____ Sex: _____

Authorization for Audio Recording, Photography or other Images, For Non Treatment Purposes Including Social Media

I hereby authorize Dr. Rod Rohrich and the Dallas Plastic Surgery Institute (DPSI) to make audio recordings or to take photographs, videotape, or digital images of me ('Images"). I understand that DPSI may use and release my images to the general public for the following purposes: (1) educational lectures and presentations for health care professionals; (2) scientific publications such as journals or books; (3) patient education materials; (4) broadcast, print or internet and social media for educational or public interest purposes.

I understand that after release of my images to the general public, they may be subject to redisclosure. I understand this authorization is voluntary and I may refuse to sign. Dr. Rod Rohrich or Dallas Plastic Surgery Institute may not condition my health care services on the completion of this authorization.

Unless otherwise revoked, I understand that this authorization will expire 50 years from the date of signature. I understand that I may revoke this authorization at any time, except to the extent that Dr. Rod Rohrich or the Dallas Plastic Surgery Institute has relied on this authorization, by sending a written statement of revocation that specifically refers to this authorization to:

Rod J. Rohrich, M.D.
Dallas Plastic Surgery Institute
9101 N. Central Expressway
Suite 600
Dallas, Texas 75231

I hereby release Dr. Rod Rohrich, Dallas Plastic Surgery Institute and employees from any and all liability connected with the capture, use or release of my images.

By signing this authorization, I acknowledge that I have read and understand the statements contained herein.

Patient:
Print Name: _____
Signature: _____
Date: _____

If Patient Has a Legal Representative, Complete the Following:
Print Name of Patient: _____
Print Name of Legal Representative: _____
Relationship to Patient: _____

By signing this authorization, I certify that I have the legal authority to serve as the above named patient's representative.
Signature of Legal Representative: _____ Date: _____

Non-Disparagement Clause

We welcome any and all comments and feedback, as it is always our goal to improve patient care and experience. By signing this agreement, you [the patient] agree not to publish false, derogatory, and injurious statements on social media or in any other public forum. In the event of a breach of this clause, you [the patient] agree to pay damages, in addition to any attorney fees incurred in defense.

_____

Patient

_____

Date

DALLAS PLASTIC SURGERY INSTITUTE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At Dallas Plastic Surgery Institute (hereafter referred to as "the Practice"), privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How - and why - information is shared

We limit who receives information and what type of information is shared.

- *Sharing information within the Practice.* We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us-whether it's at our office, over the phone or through the Internet.