

Patient Registration

#7

Referred By		Date		Account No. (Office Use Only)	
How did you hear about us?					
Would you like to be added to our mailing list? <input type="checkbox"/> Yes <input type="checkbox"/> No Thanks					
Patient					
Full Name					
Social Security No.		D.O.B.	Age	<input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Address					
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> 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
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Address _____

D.O.B.	Age	Height	Weight	Home Phone	Work Phone
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Reason for visit today? _____

Past/Current Hx (Check all applicable)

<input type="checkbox"/> Lung Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Keloids	<input type="checkbox"/> Abnormal or Excessive Bleeding
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> MRSA	<input type="checkbox"/> Taken Accutane with in Past Year
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> HIV	<input type="checkbox"/> Fever Blisters	<input type="checkbox"/> Neck Problems
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> 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 aspirin on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have excessive bleeding or bruising? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any teeth that are: <input type="checkbox"/> Loose <input type="checkbox"/> Fragile
Do you use any Tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Capped <input type="checkbox"/> False

Signature	Date
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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 **\$2,500 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 \$2,500 deposit. The deposit **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 **\$5,000 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 with the understanding that **there will be NO REFUND** if the surgery is canceled.

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

**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.

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.