DR. ROBERT PETERSON

Medical Questionnaire

Please answer all questions. Do not leave any blanks.

Y	**N**	Asthma	**Y**	**N**	Phlebitis “blood clots”
Y	**N**	Diabetes	**Y**	**N**	Blood Transfusion
Y	**N**	Migraines	**Y**	**N**	Thyroid disease
Y	**N**	Heart Disease	**Y**	**N**	Wound healing problems
Y	**N**	High Blood Pressure	**Y**	**N**	Anemia
Y	**N**	Epilepsy	**Y**	**N**	Steroids/Prednisone
Y	**N**	Seizures	**Y**	**N**	Stroke
Y	**N**	Kidney Disease	**Y**	**N**	Hepatitis

Y N Diet Pills/Herbal Supplements: Type _____

Y N Mammogram: When _____ Physician _____

Y N MRSA/Staph: When _____ Treatment _____

Y N Pain Medication Dependency: Type _____ Treatment _____

Y N Psychiatric Illnesses: Type _____ Treatment _____

Hospitalization/Surgeries:

Date | Type of Surgery | Place of Surgery | Physician

_____

_____

_____

_____

If more, please list on back of sheet

Family History of:

Please check all that apply:

___ Heart Disease | Relationship _____ ___ Cancer | Relationship _____

___ Diabetes | Relationship _____ ___ Other _____ Relationship _____

Do you:

Smoke **Y N** How much _____ Use Recreational drugs **Y N** Type _____

Use Alcohol **Y N** How often _____ Walk with a walker or cane **Y N**

Current Medications

Over the counter, herbal, nutritional, etc.

Medication Name | Dose | Frequency | Last Dose Taken

_____

_____

If more, please list on back of sheet

Allergies _____

_____

DR. ROBERT PETERSON

Patient Registration (Cosmetic)

Please fill in all blanks

Marital Status: **Single** **Divorced** **Married** **Widowed**

Mr. **Mrs.** **Ms.** **Miss** **Dr.** Patient's Name _____

Address _____ Email _____

City _____ State _____ Zip _____

Home _____ Work _____ Cell _____

Primary Care Dr. _____ Office Number _____

Social Security # _____ Date of Birth _____

Patient's Employer _____

How did you hear about us?

Friend/Family _____ Internet Insurance Magazine _____

Doctor _____ Existing Patient _____ Other _____

Spouce Information:

Spouse _____ Spouse Contact _____

Spouse DOB _____ Spouse SSN _____

Spouse Employer _____ Work _____

Photographic Consent

The following is my consent for Dr. Peterson or a staff representative to photograph me for the following purposes. Using respectful and discretionary measures, the photographs may be viewed by medical health care professionals, as well as nonmedical individuals.

____ Patient's file Photographs are required for the patient's file and will be utilized for comparative review during the course of treatment.

____ Office reference These photographs may be used for educational purposes.

____ Internet The discreet use of photographs may be used exclusively on Dr. Peterson's educational website.

By signing, I am granting Dr Peterson permission to use my photographs as checked above.

SIGNATURE _____ DATE _____

DR. ROBERT PETERSON

PAYMENT POLICY

Thank you for choosing my office for your cosmetic procedure. The staff and I are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy that we *require* you to read and sign prior to any type of treatment. All patients must complete our patient information.

We require a 20% non-refundable deposit of the surgeon's fee to guarantee your surgery date and time. Surgeries cancelled within 72 hours of scheduled surgery date will be subject to a 20% surgeon's fee.

Payment for all cosmetic surgical procedure is due in full prior to surgery. We gladly accept personal check, cash, Visa, Master Card, American Express & Discover. A $25.00 return check charge will apply to all returned checks. We do not accept postdated checks and will not hold checks.

We offer financing with Care Credit
1-800-365-8295 or www.carecredit.com

Followup Visits & Surgery Revisions

After 6 months there is a $75.00 follow up charge for all office visits. All revision or touches up surgeries are subject to hospital, anesthesia and surgeon's fee.

Other Fees

Medical Records (1st 20 pages)	$25.00
Each additional page	$0.50
Billing Records	$25.00
Postage	$4.95
Medical Leave Forms	$50.00

(Additional forms may be subject to additional charges)

I have read and understand the above information regarding payment, follow up visits, surgery revisions and other fees.

NAME _____ DATE _____