Robert Dickey Peterson, M.D., Ltd., L.L.P.
Plastic and Reconstructive Surgery
Texas Medical Arts Tower
17070 Red Oak, Suite 500
Houston, Texas 77090

Telephone (281) 893-4144
Fax (281) 583-2375

I have reviewed the office's Notice of Privacy Practice, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Signature of Patient or Personal Representative

____
Date

Print Name:__________________ **Date:______________**

Medical Questionnaire

PLEASE ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANKS

Do you have a history of:

Please circle all items

Y or N Asthma
Y or N Diabetes
Y or N Migraines
Y or N Heart Disease
Y or N High Blood Pressure
Y or N Epilepsy
Y or N Seizures
Y or N Kidney Disease
Y or N Diet Pills/Herbal Supplements: Type______________
Y or N Mammogram: When_______ Physician________________
Y or N MRSA/Staph: When________Treatment________________
Y or N Pain Medication Dependency: Type________Treatment________________
Y or N Psychiatric Illnesses: Type_________Treatment________________

Y or N Phlebitis “blood clots”
Y or N Blood Transfusion
Y or N Thyroid disease
Y or N Wound healing problems
Y or N Anemia
Y or N Steroids/Prednisone
Y or N Stroke
Y or N Hepatitis

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______) (___Diabetes; relationship_______)
(___Cancer; relationship________)(____Other not listed___________; relationship_______)

Do you:
Smoke: Y or N, How much _________________
Use Alcohol: Y or N, How often_______________
Use Recreational drugs: Y or N Type_______________
Walk with a walker or cane: Y or 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: ____

____

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Houston, TX 77090
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Patient Registration (Cosmetic)
PLEASE FILL IN ALL BLANKS

Date: ____________

GENERAL INFORMATION:

Marital Status: Single Divorced Married Widowed

Mr. Mrs. Ms. Miss Dr.

Patient'sName:____

Address: ____ Email: ______________________

City: ____________________ State:__________________ Zip:___________________________

Home: ___________________ Work: ____________________________________

Cell Phone #:________________________________

Primary Care Dr.:______________________________ Office #:__________________________

Social Security #:________________________Date of Birth: _________________

Patient's Employer:____

How did you hear about us? Friend/Family____________ Internet Insurance Magazine

Doctor_________________ Existing Patient_______________ Other___________________

SPOUSE 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 non-medical individuals.*

X 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.

_________________ ______________________________________

Date Signature

Robert Dickey Peterson, M.D. LLP, LLC

PAYMENT POLICY

Thank you for choosing my office for your cosmetic. The staff and 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.

Consultation fees are payable at the time of services. Dr. Peterson's consultation fee is $100.00.

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 post-dated checks and will not hold checks.

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

Follow-up 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 @ 50 cents	
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.

Patient signature

____Date________________