

**LAURENCE WEIDER, M.D.**  
**7777 FOREST LANE**  
**SUITE B-145**  
**DALLAS, TX 75230**

**Cosmetic Patient Demographics**

Appointment date \_\_\_\_\_

Referred by:

Reason for visit \_\_\_\_\_

Please check as many as apply.

- drweider.com
- realself.com
- breastimplantsusa.com
- loveyourlook.com
- Other \_\_\_\_\_

- Google.com
- Bing.com
- Yahoo.com
- Former patient or friend

Name of person: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_ Home# \_\_\_\_\_

Address \_\_\_\_\_ Sex M F \_\_\_\_\_ Cell# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work# \_\_\_\_\_

S.S.# \_\_\_\_\_ Age \_\_\_\_\_ D. O. B. \_\_\_\_/\_\_\_\_/\_\_\_\_ leave a message? Y N

S M W D Spouse Name \_\_\_\_\_

E-Mail Address \_\_\_\_\_ May we send you an e-mail? Y N

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

Nearest relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_

If Patient is a Minor:

Responsible person \_\_\_\_\_ Relation to patient \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED WITH NO EXCEPTION. I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO BE MADE TO LAURENCE WEIDER, M.D. ON MY BEHALF FOR ANY SERVICES RENDERED TO ME. SOME SERVICES RENDERED BY LAURENCE WEIDER, M.D. MAY NOT BE COVERED BY MY INSURANCE. I UNDERSTAND IT IS MY RESPONSIBILITY FOR PAYMENT OF SUCH SERVICES REGARDLESS OF ANY INSURANCE COVERAGE I MAY HAVE. I AUTHORIZE DR. WEIDER TO FURNISH MY INSURANCE COMPANY(S) ANY RECORDS REQUESTED BY THEM.

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**SIGNATURE OF PATIENT OR GUARDIAN**

How will you be paying for today's visit?      Cash      Credit Card /Debit      Check

***Acknowledgement of Review of Notice of Privacy Practices***

I have reviewed this office's Notice of Privacy Practices, 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

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

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PATIENT HISTORY QUESTIONNAIRE

PATIENT NAME \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_\_

Any known medication allergies? Y N If yes, lists medication and allergic reaction:

MEDICAL HISTORY: Please check the appropriate answer if you have or have had:

YES	NO		YES	NO	
___	___	Prolonged bleeding when cut	___	___	Shortness of breath/lung problems
___	___	Diabetes	___	___	Fainting or black out spells
___	___	Stomach/Intestinal disorder	___	___	Visual problems
___	___	High blood pressure	___	___	Joint pains
___	___	Heart trouble/disease	___	___	Excessive scarring
___	___	Heart murmur	___	___	Autoimmune disorder
___	___	Irregular pulse	___	___	Hepatitis
___	___	Cancer _____	___	___	Any other significant illness

If other please describe: \_\_\_\_\_

FAMILY HISTORY: Please indicate P for father's side of the family or M for mother's side:

YES	NO		YES	NO	
___	___	Diabetes	___	___	High blood pressure
___	___	Heart disease	___	___	Liver disease
___	___	Stomach/Intestinal disorders	___	___	Lung disorder
___	___	Bleeding disorders	___	___	Emotional problems
___	___	Bone or joint problems	___	___	Cancer _____

PERSONAL HISTORY:

Do you smoke? Y N If yes, how many cigarettes/packs per day? \_\_\_\_\_  
Do you drink alcohol? Y N If yes, how much and how often: \_\_\_\_\_

LIST PREVIOUS HOSPITALIZATIONS OR SURGERIES AND DATE:

\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS TAKEN REGULARLY (Including aspirin, birth control pills, herbal medications and/or dietary supplements)

Medication Name \_\_\_\_\_ Dosage/frequency \_\_\_\_\_  
Medication Name \_\_\_\_\_ Dosage/frequency \_\_\_\_\_  
Medication Name \_\_\_\_\_ Dosage/frequency \_\_\_\_\_  
Medication Name \_\_\_\_\_ Dosage/frequency \_\_\_\_\_

HAVE YOU EVER HAD A BLOOD TRANSFUSION? Y N

IF FEMALE: DATE OF YOUR LAST MENSTRUAL PERIOD? \_\_\_\_\_

HAVE YOU TAKEN ASPIRIN-CONTAINING DRUGS IN THE PAST TWO WEEKS? \_\_\_\_\_

OFFICE USE ONLY-

HISTORY REVIEWED: DATE \_\_\_\_\_ INITIALS \_\_\_\_\_ DATE \_\_\_\_\_ INITIALS \_\_\_\_\_

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FINANCIAL POLICY

Dear Patient:

Thank you for choosing us as your health care provider. We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions or concerns about these policies, please feel free to discuss them with the office manager.

Unless other arrangements have been made in advance, full payment is due at the time services are rendered. For your convenience, we accept Visa, MasterCard, and the Discover Card.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you, on an unassigned basis. In this case, your insurer will send the payment directly to you. Therefore, charges for your care and treatment are due at the time of service.

In the event that you are covered under an insurance plan of which we have made prior arrangements, you are responsible for unpaid deductibles and co-payments at the time service is rendered. However, should your insurance company deny any charges as being not covered under your plan, you will then be expected to send payment in full. You are responsible for payment of services rendered to you regardless of any insurance coverage you may have.

We understand that temporary financial problems may affect the timely payment of your balance. We encourage you to communicate any such problems to our office so that we can assist you in the management of your account.

In the unlikely event your account falls more than 90 days past due, and we have not been contacted by you to make arrangements for payment of your account, we do have a policy of turning your account over to an outside source for collection.

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PRINTED NAME OF PATIENT

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

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*RELEASE OF RECORDS*

I, \_\_\_\_\_, give authorization for the following person(s) to receive and information pertaining to my medical treatment and care from the office of Laurence Weider, M.D. I understand that the office of Laurence Weider, M.D. cannot release information to anyone that I have not provided below.

Person(s) I give authorization to:

1. \_\_\_\_\_ Relationship \_\_\_\_\_

2. \_\_\_\_\_ Relationship \_\_\_\_\_

3. \_\_\_\_\_ Relationship \_\_\_\_\_

4. \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_  
PRINTED NAME OF PATIENT

\_\_\_\_\_  
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

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*AUTHORIZATION FOR AND RELEASE OF  
MEDICAL PHOTOGRAPHS/SLIDES/ AND/OR VIDEOTAPES*

INSTRUCTIONS

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION

Medical photographs/slides and videotapes may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photography/slides, and videotapes for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Laurence Weider, M.D., and or his/her associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes. I additionally consent to photographs, slides, and/or videotapes of my interview.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Laurence Weider, M.D., and or his/her associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on electronic digital networks (the internet), for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and /or my interview.

Date: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

Witness: \_\_\_\_\_