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

Cosmetic Patient Demographics

Appointment date _____

Referred by:
Please check as many as apply.
- ☐ *www.drweider.com*
- ☐ Instagram
- ☐ *Facebook*
- ☐ *Other*_____

Reason for visit
- ☐ Realself.com
- ☐ Google.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:

_____

Are you allergic to Latex products? Y N

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, vape, or use any nicotine products? 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.

_____

PRINTED NAME OF PATIENT

_____

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: _____