LV PLASTIC SURGERY
BRIAN J. PARKER, MD

Patient's Name ____
First Middle Last

Date of Birth ________________________ Age_____________ Phone Number_________________________________

What are your main concerns for today's visit?
____
____
____

Please check the problem areas that concern you. Include anything you wish to discuss, even if it is not the main reason for your visit.

<u>Face/Neck/Eyes</u>
__ Face Lift
__ Brow Lift
__ Neck Lift
__ Upper or Lower Eyelids
__ Eyelash Growth (Latisse)

<u>Ears</u>
__ Prominent
__ Ear Lobes

<u>Nose</u>
__ Difficulty Breathing
__ Shape or Bump
__ Crooked

<u>Breast/Chest</u>
__ Breast Size
__ Breast Asymmetry
__ Breast Lift
__ Breast Reduction
__ Breast Implant Revision
__ Breast Implant Removal
__ Nipple/Areola
__ Gynecomastia

<u>Excess Skin</u>
__ Abdomen
__ Thighs
__ Arms

<u>Body</u>
__ Abdomen
__ Bra Rolls
__ Hips/Flanks
__ Inner Thighs
__ Outer Thighs
__ Knees
__ Calves
__ Arms

<u>Gynecological</u>
__ Excess Labia Tissue

<u>Skin</u>
__ Wrinkles/Fine Lines
__ Skin Texture
__ Skin Pigment
__ Dark Circles
__ Scars
__ Moles
__ Acne
__ Rashes
__ Warts

<u>Other Concerns</u>
__ Excess Sweating
__ Hand Treatments
__ Other: ___________
____
____

Please circle any of the following items that you are interested in.
Fraxel Coolsculpting Ultherapy Venus Freeze Botox Fillers Sculptra Kybella Microneedling PRP Chemical Peels

Provider Recommendations:
____
____
____
____

*** Please be advised that Dr. Parker does not participate in any insurance plans. ***

LV PLASTIC SURGERY
BRIAN J. PARKER, MD

Patient's Name: ____ Date: ______________________________
First Middle Initial Last

Street Address: ____ City, State: ______________________ Zip Code: _____________

Date of Birth:_______________________________ Age:________________ Marital Status:___________________________________

Social Security Number:____ Sex: ____Male ____Female

Cell Phone: ____ Home Phone: ____

Email Address: ____ Height:______________ Weight:________________

Employer: ____

Job Position: ____ Work Phone:____

Emergency Contact Name:________________________________ Relationship to Patient:____________________________________

Emergency Contact Phone Number:____

How did you hear about Dr. Parker?
Google Social Media Yelp Website Word of Mouth Friend:_________________________ Other____________________

Have you had any previous plastic surgery? ___________________ Were you satisfied with your results? ______________________

Who is your primary care physician? _________________________________ When was your last exam? _______________________

What specialists do you see? ____

List ALL previous surgeries and approximate dates:
____
____
____

List ALL medications you take (include prescriptions, over the counter, vitamins, supplements, herbs, etc.):
____
____
____

List ALL ALLERGIES (to medications, latex, tape, food, etc., and your reaction):
____
____
____

Do you smoke? __________ Number of years ____________ Packs per day _____________ When did you quit? _____________

Do you drink alcohol? _________________ If so, how much per week?____

Have you ever been told you need antibiotics for surgery due to a heart murmur? ____

Do you have any implanted devices (implants, pacemaker, joints, shunt, or pump)? _______________________________________

Do you have a family history of breast cancer? ______________ If so, who?____

Are you currently taking: Birth Control or Hormone Replacements? If so, what?____

Are you currently: ____ menopausal ____ peri-menopausal ____still menstruating

Number of pregnancies: _______________ Number of births: _______________ Unexplained miscarriages: _________________

Children's Ages:____ Could you be pregnant? Yes / No

Have you breastfed in the last 6 months? ___________________ If so, when did you stop?_________________________________

Have you had a hysterectomy or tubal ligation? If so, when?____

When was your last mammogram? ______________________________ Where at?_______________________________________

Check below if you have now **or** have ever had in the past any of these conditions or symptoms:

__ Diabetes	__ Night sweats	__ Basal Cell	__HIV/AIDS
__ Large weight loss/gain	__ Bloody Sputum	__ Squamous Cell	__ Bulimia
__ High blood pressure	__ Abnormal chest x-ray	__ Eczema	__ Anemia
__ Heart Disease	__ Liver disease	__ Psoriasis	__ Cancer
__ Heart Murmur	__ Hepatitis/Jaundice	__ Rosacea	__ Depression
__ MVP	__ Kidney disease/stones	__ Keloids	__ Anxiety
__ Rheumatic fever	__ Urinary problems	__ Cold sores/Herpes	__ Glaucoma
__ Circulation problems	__ Ulcers	__ Ever taken Accutane	__ Ever taken fen-phen
__ Stroke	__ Crohns/Colitis	__ Steroid therapy	__ Serious dry eyes
__ Lung disease	__ Constipation	__ Bleeding disorder	__ Alcoholism
__ Asthma, emphysema	__ Gastric Reflux	__ Epilepsy/Seizures	__ Prescription drug problem
__ Persistent cough	__ Skin Cancer	__ Thyroid problem	__ Non-prescription drug problem
__ Tuberculosis	__ Melanoma	__ Arthritis	
__ Cold sores	__ Sensitive skin	__ Reaction to Anesthesia	

Do you have any other health conditions or anything else we should know about?
____
____
____

Authorization and Acknowledgement

Initials

_____ I consent to examination and general treatment by the doctors or authorized members of the staff at LV Plastic Surgery. I understand that other consents will be required for specific procedures.

_____ I understand that any service/treatment must be paid on the day of service performed.

_____ I understand that photography is a necessary part of planning and evaluation for recommendations and treatments. I authorize the taking of photographs and videos. These photographs and videos will be for documentation and planning only. I understand that an additional consent will be required for any other use.

Signature ____ Date ________________________________

Notice of Privacy Practices Patient Acknowledgement Form
(Required by Law)

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgement. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Signature ____Date ________________________________

Communication

It is alright with me to communicate information about me (appointments, reminders, updates, test results, etc.) to the following individuals;

	Name	Relationship	Phone Number
1.	___________________________________	___________________________________	________________________________
2.	___________________________________	___________________________________	________________________________
3.	___________________________________	___________________________________	________________________________

I verify that I have provided all of my medical and surgical history to ensure my physician has all the important information to provide the safest care. I will update any new information that occurs in-between visits to include new diagnoses, new medications, subsequent surgeries and any hospitalizations. **Please be advised that Dr. Parker does not participate in any insurance plans.**

____ ____

Signature Date