

# Ricardo L. Rodriguez, M.D.

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Patient Information as of \_\_\_\_\_ (enter today's date)

(Please Print Legibly & Fill In All Fields)

Patient's Name \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_  
Street & Apt # City State Zip

SS# - - Birthdate / / Gender  Female  Male

Marital Status  Single  Married to: \_\_\_\_\_  Other: \_\_\_\_\_

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

Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Restrictions for contacting you?  No  Yes Restrictions: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

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

Ethnicity  African American  Asian  Caucasian  Hispanic  Other \_\_\_\_\_

How did you hear about Dr. Rodriguez? (Mark all that apply)

Referred by a patient: \_\_\_\_\_

Referred by physician: \_\_\_\_\_

Internet: Which site  cosmeticsurg.net  locateadoc.com  other \_\_\_\_\_

Saw cosmeticsurg.net sign  Phone Book  Magazine  Newsletter  Seminar  Salon  Not sure

Insurance Company (Please have insurance card & driver's lic available to copy) \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured name \_\_\_\_\_ Relationship \_\_\_\_\_

Dr. Rodriguez does not participate with any insurance companies however, if you have "Out-of-Network" benefits, there are some instances where insurance will reimburse if they consider the procedure as medically necessary. Please understand that most surgeries that are elective or cosmetic are not covered by any insurance. Payment is due in full prior to any procedure.

Today's Visit is For:  Cosmetic Surgery  Injury  Skin Care  Medical

Would you be interested in finding out more about  Skin Care  Hair Rejuvenation

I authorize treatment by Ricardo L. Rodriguez, MD and understand the importance of compliance with followup care. I authorize disclosure of my medical records or other information about me to any agency involved in payment for my treatment. I authorize release of my medical records related to my care with Dr. Rodriguez. I request assignment of medical insurance benefits to be made to Ricardo L. Rodriguez, MD and/or Cosmetic Surgery Facility, LLC. I understand that I personally guarantee to be financially responsible to pay Ricardo L. Rodriguez, MD for any and all charges not covered by this assignment. I understand that office visit charges are payable on the day service is rendered.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Please fill out the information below to the best of your ability. All information is confidential.**

*Please print*

Name: _____	<input type="checkbox"/> M <input type="checkbox"/> F	Age _____
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Primary Care Physician: \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

PCP's Telephone Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Current Weight \_\_\_\_\_ lbs Height \_\_\_\_\_ *Measurements if known:* Chest \_\_\_\_\_ Waist \_\_\_\_\_ Hips \_\_\_\_\_

**Check any medical problems that other doctors have diagnosed**

Diabetes  Hypertension  Cancer  Cardiovascular Disease  Pulmonary Disease  Biliary Disease  Venereal Disease  Asthma  Hepatitis  Anemia

Tuberculosis  Allergy to Latex, for example: gloves, balloons  Ulcer  Kidney Disease  Bleeding Disorders  Herpes  AIDS or HIV+

**MRSA** Yes  No  I don't know  **Other**  Please explain:

\_\_\_\_\_

\_\_\_\_\_

Have you ever had a blood transfusion? .....  Yes  No

**Surgeries/Hospitalizations**

Year	Reason	Hospital

**List your prescribed medications and over-the-counter drugs, such as vitamins and inhalers**

Name the Drug	Reason for Taking

**Allergies; medications, latex, other, please list:**

Name the Drug/other	Reaction You Had

**Women**

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_

Are you pregnant or breastfeeding? .....

Have you had a hysterectomy or tubal ligation? .....

Have you had a cesarean? .....

Experienced any recent breast tenderness, lumps or nipple discharge? .....

Date of last mammogram exam?..... / /

**Please continue to next page**

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Social & Personal		
<b>Marital Status:</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Married
	<input type="checkbox"/> Partnered	<input type="checkbox"/> Separated
	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<b>Exercise</b>	<input type="checkbox"/> Sedentary	<input type="checkbox"/> Mild Exercise
	<input type="checkbox"/> Occasional Vigorous Exercise	<input type="checkbox"/> Regular Exercise
<b>Diet</b>	Are you dieting?----- <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, are you on a physician prescribed medical diet?----- <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Alcohol</b>	Do you drink alcohol? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever experienced blackouts? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Tobacco</b>	Do you use tobacco? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Cigarettes per day _____ Number of years of tobacco use _____ Quit <input type="checkbox"/> Year _____	
<b>Drugs</b>	Do you currently use recreational or street drugs? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever given yourself street drugs with a needle? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Personal Safety</b>	Do you live alone? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have frequent falls? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have vision or hearing loss? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental Health		
Is stress a major problem for you? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you feel depressed? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you panic when stressed? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have problems with eating or your appetite? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you cry frequently? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever attempted suicide? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have trouble sleeping? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been to a counselor? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever taken psychiatric medication(s) ----- <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you currently take psychiatric medication? ----- <input type="checkbox"/> Yes <input type="checkbox"/> No		
Were you to have cosmetic surgery, please explain how you would anticipate that your life would be different following the procedure?		
_____		
Please indicate any personal history, If you need further space to write, please use the back of this form.		
<input type="checkbox"/> Skin _____ <input type="checkbox"/> Head/Neck _____ <input type="checkbox"/> Ears _____ <input type="checkbox"/> Nose _____ <input type="checkbox"/> Throat _____ <input type="checkbox"/> Lungs _____	<input type="checkbox"/> Back _____ <input type="checkbox"/> Intestinal _____ <input type="checkbox"/> Bladder _____ <input type="checkbox"/> Bowel _____ <input type="checkbox"/> Circulation _____ <input type="checkbox"/> Chest/Heart _____	<b>Recent Changes In:</b> <input type="checkbox"/> Weight _____ <input type="checkbox"/> Energy Level _____ <input type="checkbox"/> Ability to Sleep _____ <b>Other Pain/Discomfort:</b> _____
Thank you		

*Ricardo L. Rodriguez, M.D.*

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**Special Consent for Telephone Consultation**

I understand Dr. Rodriguez's office and Free Standing Outpatient Surgical Facility are located in the State of Maryland. Dr. Rodriguez is a licensed physician in the State of Maryland. The telephone consultation is not a prescribed treatment, but rather a discussion of elective surgical procedures. The telephone consultation is a means for me to get detailed information about a procedure. Any tentative surgical plans need to be confirmed by an in-person consultation with an appropriate examination and do not constitute medical treatment.

Print name: \_\_\_\_\_ Signature: \_\_\_\_\_

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