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)

Check all referral sources: ❒ Cosmeticsurg.net ❒ RealSelf.com ❒ Google Search

❒ Saw sign ❒ Patient ❒ Doctor ❒ Other ______________

Check the services that you have previously had with other physicians:

❒ Botox/Xeomin ❒ Restylane/Juvederm ❒ Other Fillers If yes, most recent injection: ______________

❒ Cosmetic Surgery - Face ❒ Cosmetic Surgery - Body/Breast If yes, date of procedure: ______________

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: ____________________ ☐ **M** ☐ **F** Age ______________

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:**

Do you use a CPAP? .... Yes No

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? .... ☐ Yes ☐ No

Have you had a hysterectomy or tubal ligation? .... ☐ Yes ☐ No

Have you had a cesarean? .... ☐ Yes ☐ No

Experienced any recent breast tenderness, lumps or nipple discharge? .... ☐ Yes ☐ No

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

Please continue to next page

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Social & Personal						
Marital Status:	☐ Single	☐ Married	☐ Partnered	☐ Separated	☐ Divorced	☐ Widowed

Exercise	☐ Sedentary ☐ Mild Exercise ☐ Occasional Vigorous Exercise ☐ Regular Exercise
Diet	Are you dieting?---------- ☐ Yes ☐ No If yes, are you on a physician prescribed medical diet?---------- ☐ Yes ☐ No
Alcohol	Do you drink alcohol? ---------- ☐ Yes ☐ No Have you ever experienced blackouts? ---------- ☐ Yes ☐ No
Tobacco	Do you use tobacco? ---------- ☐ Yes ☐ No Cigarettes per day ____________ Number of years of tobacco use ____________ Quit ☐ Year ____________
Drugs	Do you currently use recreational or street drugs? ---------- ☐ Yes ☐ No Have you ever given yourself street drugs with a needle? ---------- ☐ Yes ☐ No
Personal Safety	Do you live alone? ---------- ☐ Yes ☐ No Do you have frequent falls? ---------- ☐ Yes ☐ No Do you have vision or hearing loss? ---------- ☐ Yes ☐ No

Mental Health

Is stress a major problem for you? ---------- ☐ Yes ☐ No
Do you feel depressed? ---------- ☐ Yes ☐ No
Do you panic when stressed? ---------- ☐ Yes ☐ No
Do you have problems with eating or your appetite? ---------- ☐ Yes ☐ No
Do you cry frequently? ---------- ☐ Yes ☐ No
Have you ever attempted suicide? ---------- ☐ Yes ☐ No
Do you have trouble sleeping? ---------- ☐ Yes ☐ No
Have you ever been to a counselor? ---------- ☐ Yes ☐ No
Have you ever taken psychiatric medication(s) ---------- ☐ Yes ☐ No
Do you currently take psychiatric medication? ---------- ☐ Yes ☐ 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.

☐ Skin ____________	☐ Back ____________	**Recent Changes In:**
☐ Head/Neck ____________	☐ Intestinal ____________	☐ Weight ____________
☐ Ears ____________	☐ Bladder ____________	☐ Energy Level ____________
☐ Nose ____________	☐ Bowel ____________	☐ Ability to Sleep ____________
☐ Throat ____________	☐ Circulation ____________	**Other Pain/Discomfort:**
☐ Lungs ____________	☐ Chest/Heart ____________	____________

Thank you

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: