New Patient Form

Shaddix
PLASTIC SURGERY

Today's Date: _____ Name: *(Last)* _____ *(First)* _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

May we leave a detailed message by: **Phone** ☐ Yes ☐ No **Email** ☐ Yes ☐ No **Mail** ☐ Yes ☐ No

DOB: _____ Height: _____ Weight: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

How did you hear about us? _____

Which procedures are you interested in? _____

Allergies: _____

Current Medications including over-the-counter (ie. Aspirin) and herbal medications: _____

Medical Conditions: _____

Prior Surgeries including cosmetic: _____

Have you used nicotine in the last month (i.e. cigarettes, chewing tobacco, patches, vapes, e-cigarettes)? ☐ Yes ☐ No

Have you or a family member had an unusual reaction to anesthesia (hyperthermia, breathing problems)? ☐ Yes ☐ No

Have you or a family member ever been told that you have a clotting or bleeding disorder? ☐ Yes ☐ No

How many children do you have? _____ Did you breast feed? ☐ Yes ☐ No Are you planning to have more? ☐ Yes ☐ No

Have you experienced significant weight loss? ☐ Yes ☐ No How much? _____ Weight currently stable? ☐ Yes ☐ No

Do you have any of the following?

☐ Yes ☐ No Problems with bleeding
☐ Yes ☐ No Problems with healing
☐ Yes ☐ No Problems with scarring
☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Palpitations
☐ Yes ☐ No Shortness of breath

☐ Yes ☐ No Leg pain with walking
☐ Yes ☐ No Heart disease
☐ Yes ☐ No Lung disease
☐ Yes ☐ No Kidney disease
☐ Yes ☐ No Abdominal pain

☐ Yes ☐ No Diabetes
☐ Yes ☐ No Blood Thinners
☐ Yes ☐ No Artificial valve or joint
☐ Yes ☐ No History of MRSA
☐ Yes ☐ No Unintentional weight

For breast surgery patients:

Current bra size: Number _____ Cup _____ Desired Cup Size: _____ Prior mammogram? ☐ Yes ☐ No Date _____

Have you ever had breast cancer? ☐ Yes ☐ No Have you ever had a breast biopsy? ☐ Yes ☐ No

Do you have a family history of breast cancer? ☐ Yes ☐ No Which relatives? _____

Financial Policies

Shaddix
PLASTIC SURGERY

Use of Protected Health Information and HIPPA Compliance Policy

I give consent to Shaddix Plastic Surgery for the use and disclosure of my Protected Health Information for the purposes ofproviding treatment to me, receiving payment for services rendered to me, resolving any disputes with credit card and/or financing companies, and for general administrative operations of the practice.

Surgery Cancellation Policy

Surgical scheduling requires careful planning and coordination between our office, the Surgery Center, surgical nurses, technicians, and anesthesiologists. Special medical instrumentation is prepared and sterilized for each individual procedure. The facilities hold Dr. Shaddix accountable for time not used. Furthermore, we must turn down every other patient who desires surgery on the day and time that we have reserved for you. Therefore please understand the importance of our cancellation policy.

• Payment is required 14 days prior to the scheduled procedure date. Failure to provide payment in full by this time will result in forfeiture of the $500 booking deposit.

• Cancellation, postponement, or changes to your surgery between 8 to 14 days prior to the scheduled procedure date will result in forfeiture of 50% of the Surgeon's fee and any restocking charges for implants or other products. Hospital and anesthesia fees will be refunded if paid in advance.

• Cancellation, postponement, or changes to your surgery between 7 days prior to the scheduled procedure date will result in forfeiture of 100% of the Surgeon's fee and any restocking charges for implants or other products. Additionally, if surgery center services or any anesthesia services are utilized prior to cancellation, these fees will be charged. If no surgery center and/or anesthesia services are used, those fees will be refunded.

Surgical Complication and Revision Policy

The practice of medicine and surgery is not an exact science. I understand and accept that fees are paid for performance of the procedure(s) only, and not a guaranteed result. I acknowledge that although a good outcome is expected, and a reasonable effort has been made to establish realistic expectations, there cannot be any warranty, expressed or implied, as to the results that may be obtained.

I understand and accept that problems relating to or complications of my surgery may result in additional costs to me. These costs may include additional anesthesia and facility fees, hospital costs, physician's fees or other unspecified charges that may not be covered, or only partially covered, by my health insurance.

I understand and accept that on occasion "touch-ups" or revisions of surgery are necessary. I acknowledge that in such cases I am responsible for all operating room and anesthesia charges. I am also aware and accept that a surgeon's fee may also be charged, at my surgeon's discretion. I understand and accept that the need for, and timing of, revisions and touchups will be determined solely by my surgeon, as will the amount of the surgeon's fee.

By signing below I indicate acknowledgement and acceptance of the Use of Protected Health Information and HIPPA Compliance Policy, Surgery Cancellation Policy, and the Surgical Complication and Revision Policy of Shaddix Plastic Surgery detailed above.

Sign _____ Date _____