Roberts Cosmetic Surgery Center
Gregory D. Roberts, MD
5144 Village Creek Drive
Plano, TX 75093
972-608-0000

COSMETIC PATIENT HEALTH HISTORY

First Name:_____ Last Name:_____Date:_____

Address:_____ Date of Birth: _____ Age:_____

City:_____ State:_____ Zip:_____ Cell Phone:_____

Home Phone:_____ Work Phone: _____ Email: _____

For patient confidentiality, Roberts' staff typically will contact you via cell phone or text or email, prior to calling work or home. If you do not wish us to contact you via any of the above, please tell us: _____

SSN:_____ Marital Status: Married:_____Single:_____Divorced:_____Widow:_____

Occupation:_____ Employer: _____

WHOM MAY WE THANK FOR REFERRING YOU:_____

Family Physician:_____ Phone: _____ City/State: _____

Do we have permission to obtain additional health information from your family physician? Yes ____ No ____

Emergency Contact: _____

Emergency Contact Phone:_____ Relationship_____

Medical History:

Do you have any medication allergies or sensitivities? Yes ____ No ____ If so, please list:_____

_____

Are you currently taking any medications? Yes ____ No ____ If so, please list:_____

_____

Are you currently taking aspirin, ibuprofen, herbs, nutritional supplements, birth control pills or sexual performance drugs? Yes ____ No ____

If yes, please list: _____

_____

Have you had previous cosmetic, plastic or reconstructive surgery? Yes ____ No ____ What type of surgery? _____

_____ By Whom? _____

Were there aspects of your surgery that did not meet your expectations? Yes ____ No ____

If so, please specify: _____

_____

Have you had other types of surgery? Yes ____ No ____

Type of surgery_____Date:_____

Type of surgery_____Date:_____

Type of surgery_____Date:_____

Did you experience any complications? Yes ____ No ____

If yes, please specify: _____

_____

Roberts Cosmetic Surgery Center

COSMETIC PATIENT HEALTH HISTORY (cont.)

Have you ever had local anesthesia (Novocain, Xylocaine, etc.) by a dentist or doctor? Yes ____ No ____

Have you ever experienced an adverse reaction to anesthesia? Yes ____ No ____ When was your last physical examination?_____

If yes, please describe your reaction _____

_____

Do you have a history of bleeding? Yes ____ No ____ If yes, please specify:_____

_____

[Female Only] Are you pregnant or breastfeeding: _____

PLEASE CIRCLE YES TO ALL THAT APPLY TO YOU CURRENTLY OR IN THE PAST

Allergies	Yes	Lung Disease	Yes
Hay Fever	Yes	Kidney Disease	Yes
Nasal Allergies	Yes	Bladder Disease	Yes
Asthma	Yes	Arthritis	Yes
Vision/Eye Problems	Yes	Decreased circulation (fingers/toes)	Yes
Thyroid Disease	Yes	Gastro Esophageal Reflux	Yes
Heart Disease	Yes	Liver Disease/Hepatitis	Yes
Chest Pains	Yes	Diabetes	Yes
High/Low Blood Pressure	Yes	Skin Irritations	Yes
HIV or AIDS	Yes	Skin Rashes	Yes
Stomach Ulcers	Yes	Skin Cancer	Yes

Have you ever been under the care of a psychologist or psychiatrist? Yes If yes, please explain: _____

_____

Have you ever had (or cared for someone who has had) an antibiotic resistant infection/MRSA? Yes If yes, please explain: _____

_____

ETHNICITY: This information is very important for your aesthetician to serve you correctly and insure the best possible results for your skin treatment.

Please circle one: Caucasian / Hispanic / Asian / African American / Middle Eastern / Other (please specify) _____

Do you understand that medical and surgical treatments cannot promise or guarantee a good outcome? Yes ____ No ____

Do you understand that all risks and complications cannot be prevented when a surgical procedure is performed? Yes ____ No ____

Appointment: In effort to stay on schedule, please arrive a few minutes prior to your appointment. Being on time for your appointment assures you will receive your full service and our other clients are not inconvenienced. We reserve the right to reschedule your appointment if you are late. Please schedule your next appointment before you leave.

Cancellations: We require at least 24 hours' notice for appointment rescheduling and cancellations, as well as 14 day advance email or text notice of cancellation of a Slimlipo or surgical procedure, and a 7 day advance email or text notice of any other procedure cancelation. A fee is charged for appointments not cancelled or rescheduled without advance notice per the refund policy. Please see Roberts Cosmetic Surgery refund policy for details and charges.

Product Returns: Products may not be returned for refunds or credit applied to services. Roberts Cosmetic Surgery will not exchange products.

Insurance: Our services are cosmetic and cosmetic services are not covered by insurance plans.

_____Date:_____

Patient or Responsible Party Signature

_____Date:_____

Physician's Signature

ROBERTS COSMETIC SURGERY CENTER
CONSULTATION INFORMATION
Please Print

Date:_____ **Appointment Time:** _____ **Name:** _____

What procedure(s) are you here to discuss today:

Please check any subject in which you would like more information:

☐ Acne or Acne Scars	☐ Arm Lift (Brachioplasty)
☐ Botox or Dysport for Wrinkles or Excess Sweating	☐ Blepharoplasty Eyelid Lift
☐ Brown Spots – Melasma – Skin Discoloration	☐ Chin Augmentation
☐ Breast Augmentation, Lift or Reduction (Saline or Silicone)	☐ Drooping Eye Lids – Bags under Eyes
☐ Cheek Augmentation (Filler, Fat Transfer or Implant)	☐ Face Lift ~ Mini Lift ~ R Lift
☐ Fatty Arms, Chin, Abdomen, Love Handles, Thighs or Male Chest	☐ Forehead Lift/Brow Lift
☐ Lip Contouring or Augmentation (Filler or Removable Implant)	☐ Laser Hair Removal
☐ Liposuction (SlimLipo Dual Wavelength Laser or Traditional)	☐ Liquid Face Lift
☐ Otoplasty (Ear Surgery)	☐ Neck Lift ~ Neck Wrinkles
☐ Pharmaceutical Grade Skin Care Lotion, Sun Screen, Antioxidant	☐ Pore Tightening
☐ Radiesse, Juvederm or Voluma for wrinkles - contouring	☐ Rhinoplasty (Nose Job)
☐ Skin Rejuvenation, Tone & Texture (D.O.T. CO2, SkinPen or Peel)	☐ Sunken Cheeks
☐ Sunken Eyes/Dark Circles/Bags under eyes	☐ Thermage CPT Skin Tightening
☐ Tummy Tuck (Abdominoplasty)	☐ Wrinkles and Facial Lines

FILL OUT THE FOLLOWING TO BE ENTERED IN A DRAWING FOR $250 GIFT CERTIFICATE
This section optional ~ Gift cert may be used on any cosmetic medical procedure, except Botox, Dysport or fillers

Please tell us what prompted you to visit Roberts Cosmetic Surgery Center

(please check all that apply)

☐ Dallas Morning News	☐ Google Search
☐ RealSelf.com	☐ Roberts Cosmetic Surgery Web Site
☐ Referral (may we thank anyone:_____)	☐ Nu Image Magazine
☐ Yelp.com	☐ Facebook
☐ Living Magazine	☐ Living Well Magazine

Other:

Please tell us everywhere you have seen Roberts Cosmetic Surgery Center in the past 6 months

(please check all that apply)

☐ Dallas Morning News	☐ Google Search
☐ RealSelf.com	☐ Roberts Cosmetic Surgery Web Site
☐ Referral (may we thank anyone: _____)	☐ Nu Image Magazine
☐ Yelp.com	☐ Facebook
☐ Living Magazine	☐ Living Well Magazine

Other:

Thank you for visiting Roberts Cosmetic Surgery Center. We appreciate the opportunity to serve you.

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COMMUNICATION CONSENT

Please read the statements below and write Yes or No to give your consent.

I consent to having messages regarding my appointments, as necessary:

____Left on my cell voice mail ____Texted to my cell phone

____Left on my home voice mail ____Left with another person at my home

____Left on my office voice mail ____Mailed to my home

I give my consent to Dr. Roberts and his staff to discuss my Protected Health Information, as may be necessary, with the following people. My signing this form does not authorize the release of written Protected Health Information. I understand that I must sign a separate authorization form for the release of written Protected Health Information as stated in the Privacy Practices

(Please print legibly the name of each person on the appropriate line.)

Wife_____Phone:_____

Husband_____Phone:_____

Friend_____Phone:_____

Child (Children)_____Phone:_____

Other_____Phone:_____

From time to time, Roberts Cosmetic Surgery will email or text V.I.P. specials to existing patients. These specials are not available to the general public and do not occur more than once a month. If you would like to receive an email or text of our V.I.P. specials, please indicate below:

Anti Spam policy: We will never send more than 12 V.I.P. special emails or text messages in a year. If you desire to discontinue receiving emails, please notify us at Dr.Roberts@RobertsCosmeticSurgery.com. For texts, just reply with the word 'Stop'. Or you may call us at 972.608.0000. All future emails (or texts) will be discontinued immediately.

(Please print legibly)

☐ Yes _____ ☐ Yes _____
Email V.I.P. specials to my email address above Text V.IP. specials to my cell phone # above

_____
Patient Printed Name

_____ Date: _____
Patient Signature

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Refund Policy

Please read the following carefully:

I understand that I may choose to prepay for a procedure to reserve a treatment time or to receive special pricing. **I understand that Roberts Cosmetic Surgery Center (RCSC) does not offer any refunds**; however I may cancel any scheduled treatment and receive full credit for the prepayment to be used on any procedure offered by RCSC at a later date if my procedure is canceled per the following:

SlimLipo or Surgical: 14 days advance email or text notice
All Other Procedures: 7 days advance email or text notice

I understand that if I cancel or reschedule a D.O.T., SkinPen, Thermage or other aesthetician-performed procedure less than 7 days from the scheduled treatment date, there is a non-refundable reschedule/cancelation charge of $125. I understand this non-refundable fee is to recover costs and opportunity losses associated with procedure room reservation that are typically non-recoverable by Roberts Cosmetic Surgery. I understand that I may use the balance of the prepayment (excluding the non-refundable reschedule/cancelation charge) against any procedure offered by RCSC.

I understand that significant time is reserved for a SlimLipo or Surgical procedure. Therefore, I understand that if I cancel or reschedule a SlimLipo, liposuction or surgical procedure less than 14 days from the scheduled procedure date there is a non-refundable reschedule/cancelation charge of $750. I understand this non-refundable fee is to recover costs and opportunity losses associated with procedure room reservation that are typically non-recoverable by Roberts Cosmetic Surgery, including but not limited to anesthesia and surgical staff. I understand that I may use the balance of the prepayment (excluding the non-refundable reschedule/cancelation charge) against any procedure offered by RCSC.

_____
Patient Printed Name

_____
Patient Signature

Date:_____

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I,_____, have received a copy of
Patient Name
Roberts Cosmetic Surgery Center's **Notice of Privacy Practices** for review and I am entitled to a copy for my records upon my request.

_____
Patient Signature

_____
Printed Patient Name

Date:_____