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:**

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: