PATIENT REGISTRATION FORM

PLEASE NOTE: A non-refundable Consultation Fee of $100 is collected at scheduling. This fee is charged if you fail to arrive to your appointment, or if you cancel without the required 24-hours advanced notice. If you are more than 15 minutes late, we have the right to reschedule your appointment.

Today's Date: _____ Doctor: ☐ Dr. William M. Carpenter ☐ Dr. Christopher Derderian
☐ Dr. David E. Morales Referred By:_____

Patient Information (PLEASE PRINT)

First Name: _____ **Middle**: _____ **Last**:_____

Preferred Name: _____

Address: _____ City/State/Zip:_____

Home Phone: _____ Cell: _____ E-mail: _____

Social Security Number:_____ Birthdate:_____ Age:_____

Employer Name:_____ Work Phone:_____

Employer Address: _____ City/State/Zip:_____

Spouse:_____ Occupation:_____ Cell Phone:_____

Employer:_____ Employer Phone:_____

Primary Care Physician:_____ Main Number:_____

Address:_____ City/State/Zip _____

Nature of Visit:_____

Who to call in an emergency:

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY PRACTICES:

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I will allow the following individual(s) to have access to my medical file: _____
Relationship to patient: _____

_____ _____
Patient Signature Date

TREATMENT AUTHORIZATION: The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this staff of any changes in my medical condition. I authorize the above physician and his staff to perform the necessary treatment.

Responsible Party Signature:_____ Date:_____

MEDICAL HISTORY

(PLEASE PRINT)

Note: This is a confidential report of your medical history. Information contained here will be released only if you have authorized us to do so.

Name:_____ **Height:** _____ **Weight:** _____

Past Medical History:

Check any conditions that you have had:

- ○ Abnormal EKG
- ○ Anemia
- ○ Arthritis
- ○ Asthma
- ○ Bleeding Disorder
- ○ Breast Lump
- ○ Cancer
  Type:_____
- ○ Heart Disease
- ○ Depression
- ○ Diabetes Type I
- ○ Diabetes Type II
- ○ Epilepsy
- ○ Heart Attack
- ○ Hepatitis
- ○ High Cholesterol
- ○ HIV
- ○ Hypertension
- ○ Intestinal Disease
- ○ Lung Problems
- ○ Stroke
- ○ Thyroid
  Type:_____

Other major health problems:_____

_____

_____

Date of last mammogram: _____
(if applies)

Past Surgical History:

Have you ever had surgery? ○ Yes ○ No

If yes, please list:

Type: _____Year:_____

Type: _____Year:_____

Type: _____Year:_____

Recent Hospitalizations: _____

_____

Medications:

List all medicines and supplements you take:

Medicine or Supplements	How much?	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Are you allergic to any medications? ○ Yes ○ No

Please list: _____

_____

_____

Are you allergic to Latex? ○ Yes ○ No

Are you pregnant? ○ Yes ○ No

Have you had a tubal ligation? ○ Yes ○ No

Do you smoke? ○ Yes ○ No If you ever smoked, when did you stop? _____

Have you or anyone in your family ever had problems with general anesthetic? If so, what occurred? _____

_____

Pharmacy Name: _____ **Phone**: _____

Pharmacy Address: _____

William M. Carpenter, M.D. ♦ David E. Morales, M.D. ♦ Christopher Derderian, M.D.
4131 N Central Expwy, Suite 448
Dallas, Texas 75231

FINANCIAL AGREEMENT

INSURANCE:
Our practice does not participate with any medical insurance plans. Insurance will not be notified for coverage therefore, this is a special rate provided by the practice and by signing below you agree not to file insurance payment requests or claim reimbursement requests for any of these services, now or in the future.

Initials: _____

COSMETIC:
Procedures considered cosmetic in nature will not be billed to medical insurance companies.
I further understand that I am agreeing to be completely and solely responsible for payment of the services performed and that I will not in the future request refunds or adjustments for amounts previously paid.

Initials: _____

FMLA:
Surgeries that are cosmetic in nature will not be eligible to receive any documents relating to FMLA, short-term disability or any other type of medically related leave of absence from work. If requested, we will be able to provide you with a signed release to return to work. There is a $25 fee to obtain a copy of records.

Initials: _____

PAYMENT POLICY FOR COSMETIC SURGERY

Surgery quotes provided are effective for 90 days.
If scheduling a surgery within one month, then the total amount due to the surgeon will be collected immediately.
If the surgery date chosen is more than a month away, then a nonrefundable deposit of $1,000.00 is due at this time.
This deposit is applied toward the total amount due to the surgeon. The remaining balance of the surgeon's fee is then due three weeks before surgery. If not received by this time, we will request your surgery be rescheduled to another date.

We understand situations may arise that could cause you to postpone your surgery. Please be aware that such changes affect not only your surgeon, but also the hospital, anesthesiologist, and other patients scheduled on that day. We kindly ask you to choose your surgery date carefully.

If you need to reschedule your surgery, we will apply the $1,000.00 nonrefundable deposit to the new date if scheduled within six months of the original surgery date. A three-week notice is required for rescheduling with the benefit of transferring the deposit to the new date.
However, if you cancel your surgery without rescheduling, the $1,000.00 deposit will not be refunded. **Initials**: _____

Our practice accepts the following forms of payment for the surgeon's fee: MasterCard, Visa, Discover, American Express, Care Credit, Cash, Check, or Money Order. If writing a check, please make it payable to your surgeon and include your name and surgery date.

By signing below, I agree to have read and fully understand the terms described above.

_____	_____	_____
Patient Name	**Patient Signature**	**Date**

CONSENT FOR TAKING and USE OF PHOTOGRAPHS and DIGITAL IMAGES

Patient's Name _____

Requested by**:** (Check your doctor's name listed below.)

_____ **William M. Carpenter, M.D.**
_____ **Christopher Derderian, M.D.**
_____ **David E. Morales, M.D.**

I certify that I am the Patient or Legal Guardian of the above named patient and herby consent that photographs or digital images may be taken of the above named patient or parts of such patient's body under the following conditions and used for the following reasons:

1. The photographs or digital images may be taken at the consent of such patient's physician and shall be taken by the physician or photographer approved by the physician.
2. I authorize the physician to use my photographs or digital images for the following: insurance purposes, educational and/or scientific purposes.

(PLEASE CIRCLE "YES" OR "NO" FOLLOWING THE STATEMENT BELOW)

My **NON-IDENTIFYING** photos may be used for patient/physician education online and in print materials.

YES **NO**

I understand that all photographs and digital images viewed whether of the patient or other individuals are demonstrative in purpose and are only a representation of the possible result that could be achieved through the proposed surgery.
I understand that the patient will not ever be identified by name, but that such photographs or digital images may reveal my identity. I accept this loss of anonymity.

This authorization is granted in furtherance of medical education, knowledge, research or the general public welfare and as a voluntary contribution. I/we herby waive all right I/we might have to such photographs and digital images and do hereby release discharge and save harmless Baylor University Medical Center and its employees and agents from all claims and liabilities whatsoever in law and in equity arising from such used.

Patient/Guardian Signature: _____ **Date**: _____
Print Name of Patient _____
Witness Signature: _____ **Date:** _____