# ARTISAN COSMETIC SURGERY

| | |
|---|---|
| **Patient Name:** | **Address :** |
| | **SSN#:** |
| **Reason for Visit :** | **Date of Birth:** |

**Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply**

| | | |
|---|---|---|
| ❑ Skin care advice | ❑ Facial veins | ❑ Neck wrinkles |
| ❑ Skin care products | ❑ Facial redness | ❑ Breast size |
| ❑ BOTOX® Cosmetic | ❑ Brown spots/age spots/freckle | ❑ Abdominal area |
| ❑ Juvederm /Radiesse | ❑ Drooping brow | ❑ Hips |
| ❑ Facial fine lines/wrinkles | ❑ Drooping eyelids | ❑ Legs |
| ❑ Thin lips | ❑ Nose size or shape | ❑ Facial Contouring |
| ❑ Blotchy skin | ❑ Facial fullness/drooping | ❑ Body Contouring |
| ❑ Chemical peel | ❑ Mole removal | ❑ Unwanted Hair |
| ❑ Buttock Lift | ❑ Scar revision | ❑ Length/Fullness of Eyelashes |
| ❑ Thigh Lift | ❑ Hemangiomas | ❑ Laser Skin Tightening |

**Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.**

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

| *Younger Than* | | *True Age* | | *Older Than* |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

| *Not Concerned* | | *Somewhat Concerned* | | *Very Concerned* |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

**How did you hear about us?**

| | |
|---|---|
| ❑ My physician | *Full name:* |
| ❑ My insurance company provider | *Name:* |
| ❑ The yellow pages | *Specify Ad:* |
| ❑ A friend or family member | *Name:* |
| ❑ Internet | |
| ❑ The Physician/Practice website | |
| ❑ Seminar | *Date/location:* |
| ❑ Other | TV Ad: 11 13 24 Cable |

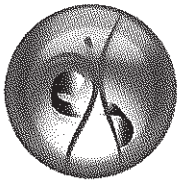
| | |
|---|---|
| ❑ Approval to contact you. | *Best phone number to reach you:* |
| ❑ Approval to send you information on products and services (including special offers) | *Email address:* |

❑ *I'm not interested in any additional services provided at this time*

**↓ For Staff Use Only ↓**

| *Follow-up* | *Date* | *Completed by (name)* |
|---|---|---|
| ❑ Initial Inquiry/Information Given | | |
| ❑ Contact in future – give date | | |
| ❑ Products | | |
| ❑ Free consultation | | |
| ❑ Procedure scheduled | | |
| ❑ Procedure completed | | |

Comments



*Let's do something beautiful*

# Artisan Cosmetic Surgery


## Manish R Gupta, MD, Robert S Myers MD

1050 Isaac Streets Drive • Suite 136 • Oregon OH 43616 • 419 696-5656
3438 Granite Circle • Toledo OH 43617 • 419 841-2303
www.ArtisanCosmeticSurgery.com


Name_____ Date _____
Last First Middle

Address_____ City _____ State___ Zip_____

Home Phone _____ Cell Phone_____ Wk Phone _____

Date of Birth _____ SSN#_____Email _____

Preferred Language _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

How did you hear about Dr. Gupta/Dr. Myers/Artisan Cosmetic Surgery?

TV • Website • Newspaper • Yellow Pages • Referral • Other

Can we leave a message for you at home? Yes No *Cell Phone*? Yes No *At Work*? Yes No

Can we send e-mails to the address you provided? Yes No Can we send info to your home? Yes No

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Occupation _____ Employer _____

Primary Care Physician: _____
Name Address Phone

Referring Physician: _____
Name Address Phone

In case of emergency, contact:_____
Name Address Phone

# Patient History Questionnaire

**Print Name**:_____ **DOB**:_____ **Sex**:_____

What is the reason for your visit?_____

Please Provide the Name, location and phone number to your pharmacy:
_____

Do you smoke? □Yes □No If yes how much?_____
Height: _____ Weight: _____

**Medications**: Prescriptions and non-prescriptions, vitamins, home remedies and herbs:

| Medication | Dose | Per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Medication | Dose | Per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Allergies or Reactions to Medicines/ Foods/ Other Agents:**

| Medication/Foods | Reaction or Side Effect |
|---|---|
| | |
| | |
| | |

List any Surgeries:

_____ _____
_____ _____

Have you or anyone in your family ever had problems with anesthesia? □Yes □No
Are you currently taking blood thinners? □Yes □No
Is there any history of breast cancer in your family? □Yes □No

**The questions below pertain to you only, not family**.

| | | | | | |
|---|---|---|---|---|---|
| Bleeding Problems | □ yes | □ no | Respiratory Problems | □ yes | □ no |
| Anemia | □ yes | □ no | COPD, Emphysema | □ yes | □ no |
| Heart Problems | □ yes | □ no | Sleep Apnea | □ yes | □ no |
| Pacemaker | □ yes | □ no | Stomach Problems | □ yes | □ no |
| High Blood Pressure | □ yes | □ no | Acid Reflux | □ yes | □ no |
| Stroke | □ yes | □ no | Kidney or Liver Disease | □ yes | □ no |
| Diabetic | □ yes | □ no | Seizures | □ yes | □ no |
| Hepatitis, TB, HIV | □ yes | □ no | Cancer | □ yes | □ no |

Do you have any diseases, conditions, or problems not listed?_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or in my medications, I will inform the doctor.

_____ _____
**Signature** **Date**

## PLEASE READ CAREFULLY

## HIPAA NOTICE OF PRIVACY POLICY ACKNOWLEDGMENT

I have been given the opportunity to review the HIPAA Privacy Policy of Artisan Cosmetic Surgery, Dr. Manish Gupta and Dr. Robert Myers. I was provided with ample opportunity to ask any questions regarding the Privacy Policy and I understand that I may have the full Privacy policy in writing at my request.

_____

Patient Signature

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____.

"Physician" shall be understood to mean Manish Gupta MD, Robert Myers MD, Artisan Cosmetic Surgery, and Manish Raj Gupta MD PC.

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Society of Plastic Surgery.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the American Society of Plastic Surgery and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members. I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and Patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____ _____

Physician Patient/Guardian

_____ _____

Effective from Date of Treatment: Date of Signature

**Photo Consent**

Medical photographs/slides and videotapes may be taken before, during, or after a surgical procedure of treatment. Consent is required to take such images. I hereby authorized Manish R. Gupta, MD, Robert Myers, MD and/or their associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes. I additionally consent to photographs, slides, and/or videotapes of my interview. I hereby authorized Manish R Gupta, MD, Robert Myers, MD and/or their associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures in medical lay groups. I consent to the photographing or televising of the operation(s) or procedures(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, providing my identity is not revealed by the pictures. Provided my identity is not revealed by the pictures, I understand that my photos may be used for the purposes of advertising, in print, video, or digital medium, including internet-based web-sites.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview. I hereby grant permissions for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by the America Board of Plastic Surgery, Inc.

**Yes, I have read the Photo Consent Form: I am in agreement and give my consent.**

_____ (Patient) _____ (Date)

_____(Witness)