



Let's do something beautiful

Artisan Cosmetic Surgery

Manish R Gupta, MD, Robert S Myers MD

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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

Occupation _____ Employer _____

Primary Care Physician: _____
Name Address Phone

Referring Physician: _____
Name Address Phone

In case of emergency, contact: _____
Name Address Phone

Name of Primary Insurance Company _____

Address _____

City _____ State _____ Zip _____

Insured's Name _____

Group Number _____ Policy ID Number _____

Name of Secondary Insurance Company _____

Address _____

City _____ State _____ Zip _____

Insured's Name _____

Group Number _____ Policy ID Number _____

*Complete this section only if someone other than the patient is financially responsible (spouse/ parent)

Name _____ Address _____

DOB _____ SS# _____

Important: MCO Company Information (Work related injury)

Did you injury happen on the job? Yes No If yes please complete the following:

On what date did the injury occur?

Did you report the accident to your employer? Yes No

MCO Company _____

Contact Person _____ Claim # _____

Work Phone () _____ Fax () _____

*Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts.

*Signature/Date of Patient or Responsible Party: _____
Name Date

*I authorize the release of any medical information necessary to process my claim. _____
Patient or responsible party/Date

*I authorize payment of medical and surgical benefits to Manish R. Gupta, MD. _____
Patient or responsible party/Date

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 <input type="checkbox"/> yes <input type="checkbox"/> no	Respiratory Problems <input type="checkbox"/> yes <input type="checkbox"/> no
Anemia <input type="checkbox"/> yes <input type="checkbox"/> no	COPD, Emphysema <input type="checkbox"/> yes <input type="checkbox"/> no
Heart Problems <input type="checkbox"/> yes <input type="checkbox"/> no	Sleep Apnea <input type="checkbox"/> yes <input type="checkbox"/> no
Pacemaker <input type="checkbox"/> yes <input type="checkbox"/> no	Stomach Problems <input type="checkbox"/> yes <input type="checkbox"/> no
High Blood Pressure <input type="checkbox"/> yes <input type="checkbox"/> no	Acid Reflux <input type="checkbox"/> yes <input type="checkbox"/> no
Stroke <input type="checkbox"/> yes <input type="checkbox"/> no	Kidney or Liver Disease <input type="checkbox"/> yes <input type="checkbox"/> no
Diabetic <input type="checkbox"/> yes <input type="checkbox"/> no	Seizures <input type="checkbox"/> yes <input type="checkbox"/> no
Hepatitis, TB, HIV <input type="checkbox"/> yes <input type="checkbox"/> no	Cancer <input type="checkbox"/> yes <input type="checkbox"/> 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

“T”, “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)