DR. CRAIG OSER
PLASTIC SURGERY AND MED SPA
DROSER.COM

PATIENT INTAKE FORM - MED SPA

In order for our office to best prepare for your visit, please complete the information below and bring this form with you on the day of your consultation.

PATIENT INFORMATION

Full Legal Name: _____ /_____ /_____
Last Name First Name Middle Int.

Age: _____ Date of Birth: _____ /_____ /_____ S.S. #: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Home: (____) _____-_____ Mobile: (____) _____-_____ Work: (____) _____-_____

Do we have consent to call you and leave a message? ☐ Yes ☐ No

If yes, on what number: *(Check all that apply.)* ☐ Home ☐ Work ☐ Cell Phone

What is the best time to reach you? Morning / Afternoon / Evening

Email address: _____

May we email you promotions and/or specials: ☐ Yes ☐ No
(Please be aware that email is not a secure form of communication and that the discussion of your medical care will become part of your medical record.)

What way do you approve and prefer we communicate with you between office visits?
(Check all that apply.)(By checking the box, you are giving consent for the office to communicate by that method.)

☐ E-mail ☐ Home ☐ Work ☐ Cell Phone ☐ Text

Is there any place you do NOT want me to leave a message? _____

REFERRAL SOURCE

How were you referred to us? _____

How did you hear about us? *(Please check all that apply and list specific station, website or event.)*

TV: _____ Billboard: _____ Radio: _____ Internet: _____ Social Media: _____ Other: _____

GENDER

Female _____ Male _____

MEASUREMENTS

Height _____ Weight _____

MARITAL STATUS

Single _____ Married _____ Widow _____ Separated_____ Divorced_____ Other_____

OCCUPATION

Title: _____ *(Full time/Part time/Student/Retired)*

Employer/School: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Craig Oser, DO, FACOS, FACS
One Robinson Plaza • Suite 230 • Pittsburgh, PA 15205
Office: 1.844.4DROSER • Fax: 724.909.1711

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EMERGENCY CONTACT

Name: _____ Relationship: _____

Home: (____) _____-_____ Mobile: (____) _____-_____ Work: (____) _____-_____

MEDICAL CONTACT INFORMATION

Family Physician: _____ Phone # (____) _____-_____

Referring Physician: _____ Phone # (____) _____-_____

Dermatologist: _____ Phone # (____) _____-_____

Pharmacy: _____ Phone # (____) _____-_____

TODAY'S VISIT

What brings you to our office? Please be as specific as possible.

_____

_____

How long has this concerned you? _____

Have you had any previous treatment for this? _____

If yes, how and when was this treated?_____

ADDITIONAL PROBLEM AREAS:

PROBLEM AREA	DESCRIPTION	TRIED TREATMENT
Face		
Body		
Breast		
Skin		
Other		

Please let us know any problem areas that you would like to discuss.

Is there anything else you would like to discuss at today's visit? If yes, please describe?

_____

Are there any procedures you are interested in speaking with Dr. Craig Oser about?

_____

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PATIENT MEDICAL HISTORY

CHECK LIST SELF REVIEW

	YES	NO	DESCRIPTION
Have you used Accutane in the past 6 months?			If yes, how recent?
Are you currently using glycolic acid or Retin-A?			
What products are you currently using on your skin?			
Do you have any active skin diseases or infections in the area to be treated?			
Are you allergic to latex, lidocaine or any lotions?			
Do you have any metal or other implants?			If yes, please describe
Have you had any previous laser treatment or other skin treatments to the area to be treated?			
Do you have a history of skin breakouts?			
Do you have scarring as a result from your breakouts?			
Have you been exposed to the sun in the last four to six weeks?			If yes, approximate date?
Do you use tanning beds?			If yes, date of last use?
Do you burn easily in moderate sunlight?			
Do you blush easily?			
Do you frequently experience flakiness, tightness or dryness?			
Do you use sunscreen on a regular basis?			
Have you waxed, used depilatories, bleaches or other chemical processes?			
Have you had any chemical peels?			
Have you had laser resurfacing?			
Do you have wrinkle concerns?			
Do you have pigmentation concerns?			
Do you have broken capillary concerns?			

Are you in general good health? ☐ Yes ☐ No

If no, please explain: _____

Do you have any relatives who have had breast cancer? _____

If yes, who? _____

Have you ever had a mammogram? ☐ Yes ☐ No

If yes, when was your last one? _____

Have you or a member of your family ever had a problem with anesthesia? ☐ Yes ☐ No

Have you ever had radiation? ☐ Yes ☐ No

Have you been exposed to excessive sun? ☐ Yes ☐ No

Do you or any family member have problems with prolonged bleeding when cut? ☐ Yes ☐ No

Do you or any family member have problems with bruising easily? ☐ Yes ☐ No

Do you or any family member have problems with excessive scarring or keloid formation after being cut? ☐ Yes ☐ No

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Do you wear contacts? ☐ Yes ☐ No

Do you have any problems with dry eyes? ☐ Yes ☐ No

Do you use wetting drops? ☐ Yes ☐ No If yes, how often? _____ How long? _____

If Female: Is there a chance that you might be pregnant? ☐ Yes ☐ No

Date of last menstrual cycle: _____

Your genetic background affects your skin and its response to the laser. Please specify your ethnic origin:

☐ African American ☐ Caucasian ☐ Mediterranean ☐ Native American

☐ Asian ☐ Hispanic ☐ Middle Eastern ☐ Other: _____

Do you suffer from any of the following? Please check all that apply.

- ☐ Acne
- ☐ Bleeding Disorders
- ☐ Burns/Skin Grafts
- ☐ Claustrophobia
- ☐ Seizures
- ☐ Shingles
- ☐ Skin Cancer
- ☐ Tattoos
- ☐ Gold Therapy
- ☐ Heart Disease
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hirsutism
- ☐ Hormone Replacement Rx
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Endocrine Disorders
- ☐ Epidermolysis Bullosa
- ☐ Polycystic Ovary Disease
- ☐ Port-Wine Stain
- ☐ Hepatitis
- ☐ Precocious Puberty
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Implants
- ☐ Kaposi's Sarcoma
- ☐ Keloid Scars
- ☐ Lupus Erythematosus
- ☐ Thyroid Disease
- ☐ Vitiligo
- ☐ Permanent Makeup
- ☐ HIV/AIDS
- ☐ Other: _____

MEDICATIONS AND SUPPLEMENTS

What medications *(prescribed or over the counter)* are you currently taking? Please list all medications including prescription and over the counter drugs, vitamins, herbs, blood thinners, aspirin, and/or supplements.

_____

_____

What medications have you previously taken?

_____

_____

ALLERGIES

Do you have any known allergies? ☐ Yes ☐ No

If so, please list: _____

Do you have any known food, drug or latex allergies? ☐ Yes ☐ No

If yes, please list: _____

Do you have any known contagious diseases at this time? ☐ Yes ☐ No

If yes, what? _____

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SURGICAL HISTORY

Have you had any hospitalizations or surgeries? If so, please list and be sure to include dates:

_____

_____

SOCIAL HISTORY

Do you consume or have you consumed any of the following?

1. Tobacco? ___ YES ___ NO If yes, type? _____ How much? _____ How often? _____ How long? _____
2. Alcohol? ___ YES ___ NO If yes, type? _____ How often? _____
3. Caffeinated Beverages ___ YES ___ NO If yes, How often? _____
4. Street Drugs ___ YES ___ NO If yes, drug of choice? _____ ** Please discuss with doctor

FAMILY HISTORY

Please indicate if there have been any of the following diseases in you, your parents, grandparents, siblings, or children. Please mark family members on appropriate line:

Cancer _____	Stroke _____	Asthma _____	HIV _____
Diabetes _____	Anemia _____	Mental Illness _____	Hepatitis _____
Epilepsy _____	Kidney Disease _____	Arthritis _____	Bypass _____
Heart Disease _____	Glaucoma _____	Tuberculosis _____	Heart Attack _____
High Blood Pressure _____	Allergies _____	Alzheimer's _____	Other _____

If yes or other, please specify _____

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, hereby authorize physicians, agents and employees of Dr. Craig Oser to furnish such emergency care, outpatient care and/or inpatient care including but not limited, to investigative or diagnostic procedures, examinations, anesthesia, medical and/or surgical treatment which, in the judgment of the patient's attending physician, is recommended or necessary for the treatment of the patient's illness or condition. I understand it is solely within the capability of the physician(s) and/or his assistant(s) to explain to me the nature of any diagnostic, medical and/or surgical procedures necessary to treat me, or the registered patient and to explain the risks of consequences with the procedures.

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

CANCELLATION/NO SHOW POLICY FOR DOCTOR APPOINTMENT

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance, you will be charged a ($25) fee.

SCHEDULED APPOINTMENTS

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time, we must reschedule the appointment.

Patient's Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE AND CONSENT OF MEDICAL PHOTOGRAPHS, VIDEOS AND/OR TO PUBLISH

Please read this information carefully and completely concerning granting permission to take and use photographs, videos and/or testimonials. After reviewing, please sign the consent as proposed by Dr. Craig Oser Plastic Surgery and Med Spa.

I hereby authorize Dr. Craig Oser Plastic Surgery and Med Spa and his associates or licensees the right to use my photographs, videos and/or testimonials taken that showcase me and/or the procedure that I am having performed:

☐ **Snapchat**
☐ With eyes showing ☐ Without eyes showing

☐ **Instagram**
☐ With eyes showing ☐ Without eyes showing

☐ **Facebook**
☐ With eyes showing ☐ Without eyes showing

☐ **Twitter**
☐ With eyes showing ☐ Without eyes showing

☐ I hereby grant Dr. Craig Oser Plastic Surgery and Med Spa the right to use my photographs, videos and/or testimonials on their website **(photo gallery, blogs, etc.)**

☐ I hereby grant Dr. Craig Oser Plastic Surgery and Med Spa the right to use my photographs, videos and/or testimonials for professional medical purposes, including but not limited to, showing these images on electronic digital networks for purposes of medical education, patient education, lay publication, advertising and marketing or during lectures to medical or lay groups.

PLEASE PRINT THE FOLLOWING

Patient Name:_____ Date of Birth: _____

Email Address: _____ Telephone: _____

Procedure(s): _____

Physician/Service Provider: _____ Date of Procedure: _____

I hereby certify that I am over 18 years old and that it is my intention to be legally bound by this agreement.

I understand that photographs and/or videos may be taken preoperative, intraoperative and postoperative and at any stage of my procedure and may contain recognizable images of my face and/or body. I understand that all information will be kept confidential and will be reported in an anonymous fashion. I will not be described by name in any publication.

The information, photographs, videos and/or testimonials disclosed under this consent, or some portion thereof, are protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any use or disclosure of such information, photographs, videos and/or testimonials carries with it the potential for an unauthorized redisclosure. I release Dr. Craig Oser Plastic Surgery and Med Spa, its agents and employees, from all liability in connection with any such redisclosure and/or disclosure and/or use of information, photographs, videos and/or testimonials by individuals and/or entities other than Dr. Craig Oser Plastic Surgery and Med Spa and its agents and employees.

I release Dr. Craig Oser Plastic Surgery and Med Spa, its agents and employees, from all liability in connection with information, photographs, videos and/or testimonials of me authorized pursuant to this release and consent. I waive any right to inspect or approve the information, photographs, videos and/or testimonials prior to use. I release Dr. Craig Oser Plastic Surgery and Med Spa, its agents and employees, from any claim I may have relating to use of the information, photographs, videos and/or testimonials, including any claim for payment in connection with the use of them.

I understand that I may revoke this consent at any time by providing a written request. If I do so revoke this consent, it will have no affect on any use or disclosure of photographs, videos or testimonials prior to the revocation date.

I may refuse to sign this Release and Consent without such refusal affecting the medical treatment I receive with Dr. Craig Oser Plastic Surgery and Med Spa.

Signature: _____ Date: _____

Witness: _____ Date: _____

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