Date____/____/_____

Name:_____ Date of Birth_____/_____/_____ Age_____ Sex M F

Address:_____ City:_____State:_____ Zip:_____

Hm Phone:_____ Wk Phone:_____

Cell Phone:_____E-mail:_____

Emergency contact:_____Phone:_____Relationship:_____

How were you referred to our office? _____May we contact you at home?_____Email_____Cell_____

Please check off the other procedures which are of interest to you.

☐ Botox ☐ Cosmetic Fillers ☐ Photo Rejuvenation ☐ Vein Treatment ☐ Ablation (stopflow) ☐ Lipo ☐ Breast Aug

HISTORY

Are you under the care of a physician at this time? ☐ Yes ☐ No If yes, what is the condition?_____

Do you use or have you used recreational drugs? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

Are you on a special Diet? ☐ Yes ☐ No Height _____ Weight_____ Do you fluctuate in weight? _____

By how much?_____ Would you be interested in a weight loss program before/after surgery? ☐ Yes ☐ No

Have you taken the prescription drugs Fenfluramine, Fenfluramine combined with Phentermine? ☐ Yes ☐ No

(Fen-Phen), Dexfenfluramine (Redux), or other weight loss products? ☐ Yes ☐ No

Have you ever had any of the following?

Extensive bleeding which required special treatment? ☐ Yes ☐ No If yes, explain?_____

Medical cosmetic treatments? ☐ Yes ☐ No If yes, explain?_____

Lipo, Fractional or laser assisted surgery? ☐ Yes ☐ No If yes, explain?_____

Any complications with previous surgery? ☐ Yes ☐ No If yes, explain?_____

Abnormal or inguinal hernias? ☐ Yes ☐ No Blood transfusion? ☐ Yes ☐ No

Previous back injury or nerve injuries? ☐ Yes ☐ No Chronic viral infections? ☐ Yes ☐ No

Any family history of severe reaction to anesthesia or malignant hyperthermia? ☐ Yes ☐ No

Personal or family history of blood clots in legs or lungs or leg swelling? ☐ Yes ☐ No

Do you have any periodontal or dental disease? ☐ Yes ☐ No

Has a root canal be recommended to you? ☐ Yes ☐ No

Last pap? _____ Last Colonoscopy?_____ Last Bone density scan?_____Last Mammogram?_____

Ladies

How many pregnancies?_____Are you pregnant? ☐ Yes ☐ No

Method of contraception: ☐ Vasectomy ☐ Tubal ☐ Pill/Patch ☐ Injectable ☐ IUD ☐ Barrier ☐ Essure

Last menstrual period?_____How long is your period?_____

Do you experience bleeding between periods? ☐ Yes ☐ No

Drug Allergies:_____

Past Medical History		Past Surgical History/Year	Current Medications Name/Dosage
☐ Hypertension	☐ Kidney disorder	☐ Gallbladder _____	_____
☐ Diabetes	☐ Bleeding disorder	☐ Tonsils _____	_____
☐ Asthma	☐ Thyroid disease	☐ Hysterectomy _____	_____
☐ Seizures	☐ Cardiac pacemaker	☐ Heart Surgery _____	_____
☐ Heart disease	☐ Cholesterol disorder	☐ Appendix _____	_____
☐ Stroke	☐ HIV	☐ Colon _____	_____
☐ Cancer	Other_____	☐ Other _____	_____
☐ Liver Disease	_____		
☐ Hepatitis	_____		

Patient Communication Authorization

Date: _____

Patient's Name: _____

Date of Birth: _____

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

__ It's okay to call my home phone number Okay to leave a message? __ yes __no

__ It's okay to call my mobile number Okay to leave a message? __yes __no

__ It's okay to call my work phone number. Okay to leave a message? __yes __no

__ Call only this number. _____ Okay to leave a message? __yes __no

__ Do not speak to family members.

I give permission to the individual(s) listed below to receive protected health information:

_____

_____

This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature_____Date_____

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

Section 1: I agree to binding arbitration to resolve any claim I may have against Keri Sweeten, M.D., or her staff. If I wish to assert a claim for medical malpractice, including any claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, I agree that such claim will be submitted to binding arbitration by the American Arbitration Association, and not by a lawsuit or resort to court proceedings. I agree that both parties to this contract are giving up their constitutional right to have any such claim decided in a court of law before a jury, and instead are agreeing to binding arbitration. I understand that binding arbitration means that a private arbitrator or arbitrators, and not a judge or jury, will decide my claim and that the arbitrator's decision ordinarily will be final.

Section 2: I agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to the treatment or services provided by Dr. Sweeten or her staff, including my spouse or heirs and any children, whether born or unborn. This Agreement covers all claims for monetary damages including, without limitation, suits for loss of consortium and companionship, wrongful death, emotional distress and punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against Dr. Sweeten and any employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of any parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement.

Section 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Section 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE DR. SWEETEN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND LATER CHANGE MY MIND, I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO DR. SWEETEN WITHIN 30 DAYS STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT. I ALSO UNDERSTAND THAT I MAY HAVE MY ATTORNEY OR OTHER ADVISORS DISCUSS THIS AGREEMENT WITH DR. SWEETEN OR HER STAFF, AND THAT I OR ANY SUCH REPRESENTATIVE MAY REQUEST REVISIONS TO THIS AGREEMENT.

Section 5. OPTIONAL: RETROACTIVE EFFECT
If I intend this Agreement to cover services rendered before the date it is signed (for example, prior emergency treatment), I have indicated the earlier effective date below. Otherwise this Agreement covers only services rendered after this Agreement was signed.

Earlier effective date: _____ Patient's Initials: _____

Section 6. I have read and understood this Agreement. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

BY SIGNING THIS CONTRACT I AM AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND TO GIVE UP MY RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 of THIS CONTRACT.

_____ Dated: _____, 20____.
(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship: _____

PHYSICIAN'S AGREEMENT TO ARBITRATE
In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by arbitration on the terms set forth in this Agreement.

_____ Dated: _____, 20__.
(Physician or Duly-Authorized Representative)

_____ Dated: _____, 20__.
Print name of Physician, Medical Group, Partnership or Association

Information about our Arbitration Agreement.

To Our Valued Patients:

We would like to explain our policy regarding our Arbitration Agreement. We are concerned about the rising cost for medical liability insurance and the growing number of physicians who are leaving the practice of medicine because of the threat of malpractice litigation. It is our feeling that our Arbitration Agreement discourages frivolous litigation, and may help prevent increases in medical liability insurance premiums. Binding arbitration can also resolve claims more quickly and at less expense than court proceedings, and can avoid years of appeals. We believe this benefits both the patient and the physician.

The American Arbitration Association is a nationally-recognized organization which has qualified neutral arbitrators available to decide claims in a prompt and fair manner.

We are very grateful for your understanding and cooperation in this matter. Please feel free to discuss any concerns with our physicians or our office manager.

We will understand and respect your decision if you elect not to sign this Agreement. If you decide not to sign the Agreement, then we will happily see you in consultation today and for the next 30 days; after this 30-day period we would request that you seek further care with another physician. We can provide you with the names of other surgeons.

Sincerely,

Keri Sweeten, M.D.

Medication and Foods that Potentially Interact with Tumescent Anesthetic

Circle if you are taking any of the following:

Anesthetics
propofol (Diprovan)

Antibiotics/antimicrobials
clarithromycin (Biaxin)
chloramphenicol (Chloromycetin)
erythromycin
isoniazid
tetracycline
troleandomycin (TAO)

Anti-cardiac arrhythmia (antidysrhythmic) drugs
propafenone (Rythmol)
quinidine (Quinaglute, Quinidex)

Antidepressants
amitriptyline (Elavil) clomipramine (Anafranil) fluoxetine (Prozac) fluvoxamine (Luvox) nefazodone (Serzone) paroxetine (Paxil) sertraline (Zoloft)

Antiestrogen
tamoxifen (Nolvadex)

Antifungal Medications
fluconazole (Diflucan)
itraconazole (Sporanox)
ketoconazole (Nizoral)
metronidazole (Flagyl) miconazole (Monistat)

Antihistamines
astemizole (Hismanal)
terfenadine (Seldane)

Antiseizure medications
carbamazepine (Tegretol)
divalproex (Depakote)
valproic acid (Depakene)

Benzodiazepines
alprazolam (Xanax)
flurazepam (Dalmane)
midazolam (Versed)
triazolam (Halcion)

Beta blocker
propranolol (Inderal)

Beverage
grapefruit juice

Calcium channel blockers
amiodarone (Cordarone)
diltiazem (Cardizem) felodipine (Plendil) nicardipine (Cardene) nifedipine (Procardia) verapamil (Calan)

H_2 Blockers
cimetidine (Tagamet)

Hormones
thyroxine ethinylestradiol

Immunosuppressants
cyclosporine (Neoral, Sandimmune)

Miscellaneous
danozol (Danocrine)
methadone mibefradil (Posicor)
pentoxifylline (Trental)
zileuton (Zyflo)

Protease inhibitors
indinavir (Crixivan)
nelfinavir (Viracept)
ritonavir (Norvir)
saquinavir (Invirase)

Psychotherapeutic drugs
clozapine (Clozaril)
pimozide (Orap)

Steroidal Antiinflammatory drugs
dexamethasone (Decadron)
methylprednisolone
prednisone

Print Name _____

Patient Signature_____