



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

- Hypertension
- Diabetes
- Asthma
- Seizures
- Heart disease
- Stroke
- Cancer
- Liver Disease
- Hepatitis
- Kidney disorder
- Bleeding disorder
- Thyroid disease
- Cardiac pacemaker
- Cholesterol disorder
- HIV
- Other _____

Past Surgical History/Year

- Gallbladder _____
- Tonsils _____
- Hysterectomy _____
- Heart Surgery _____
- Appendix _____
- Colon _____
- Other _____

Current Medications Name/Dosage

- _____
- _____
- _____
- _____
- _____
- _____



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.

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

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.

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

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



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 Tumescant Anesthetic

Circle if you are taking any of the following:

Anesthetics

propofol (Diprivan)

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)

Anti-estrogen

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) nifedipine (Cardene)
nifedipine (Procardia) verapamil (Calan)

H₂ 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 _____