

Otto Huertas MD PA

REGISTRATION FORM

(Please print)										
Today's date:					PCP:					
PATIENT INFORMATION										
Patient's last name:			First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name?		If not, what is your legal name?			(Former name):		Birth date:		Age:	Sex:
<input type="checkbox"/> Yes	<input type="checkbox"/> No						/ /			<input type="checkbox"/> M <input type="checkbox"/> F
Street address:				Social Security no. (optional):			Home phone no.:			
							()			
City:		State:			Zip Code:		Cell phone no.:			
							()			
E-mail:										
Occupation:		Employer:				Employer phone no.:				
						()				
Referred to office by (please check one box):					<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan			<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other				
Family member(s) seen here?:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please provide us her/his name:						
IN CASE OF EMERGENCY										
Name of local friend or relative (not living at same address):				Relationship to patient:		Home phone no.:		Work phone no.:		
						()		()		
How do you plan to pay for your surgery?				<input type="checkbox"/> Cash		<input type="checkbox"/> Care Credit		<input type="checkbox"/> Credit Card		
Please read and initial each line:										
_____ The above information is true to the best of my knowledge.										
_____ I understand that cosmetic surgery is an elective procedure and IS NOT covered by insurance, placing full responsibility for payment upon the patient.										
_____ I understand that if I fail to attend to my appointment there is a \$50.00 no show fee.										
_____ I understand that if I get at least 10 min late to any follow up appointment, I may be ask to reschedule.										
_____ I understand that if I am over 35 years old or have any medical condition, it is required to have a medical clearance.										
<i>Patient/Guardian signature</i>					<i>Date</i>					

Height: _____ Weight: _____ Maximum weight: _____

Female patients: Pregnancies: _____ Deliveries: _____ Last menstrual cycle: _____

Allergies: _____ Do you smoke? Yes No

Medications: _____

Previous Surgeries: _____

Prior liposuction? Yes No Complications with previous surgeries? Yes No

Areas desired for liposuction: _____

Do you have a history of any of the following?: (**Circle**) hepatitis disease, liver disease, heart problems, irregular heartbeat, strokes, high blood pressure, high cholesterol, abdominal or inguinal hernias, asthma, lung problems, back injury, nerve injuries, seizures, neurologic or psychiatric problems, diabetes, kidney or thyroid problems, blood clots in legs or lungs, leg swelling, blood transfusions, chronic viral infection?

Other medical problems: _____

Pharmacy name and location: _____ Phone number: _____

Otto Huertas MD PA

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PATIENT NAME: _____ DOB: ____/____/____

Otto Huertas MD PA Appointment, Rescheduling & Cancellation Policies

FULL PAYMENT must be received in order for us to add you in our schedule.

If your quote is for more than four (4) areas, we will have to schedule two (2) separate surgery dates; if for any reason you do not want to continue with the second part, no money will be refunded. The second surgery date CAN NOT exceed 6 weeks from the 1st surgery.

We schedule our patient's surgery days and times according to the areas being done. This allows us to better estimate how long each procedure will take in order to schedule flow to run efficiently. We do understand that everyone's time is quite valuable. In order to keep our schedule running smoothly, we have implemented the policies below.

Please read each policy and place your initials at the end of each statement indicating that you understand and agree to the policy.

Late Policy: All patients are expected to arrive 30 minutes before their schedule surgery time. *If you are late for your scheduled time, there will be a \$50.00 fee for every 15 minutes you are late. If you are 30 minutes late, your appointment may need to be reschedule to another date and time and you will be charged a \$650.00 rescheduling fee.* Traffic, weather, car delays and other issues cannot be foreseen so it is very important to plan ahead with the expectation of arriving well in advanced of your scheduled appointment time. **Patient's initials:** _____

Rescheduling Policy: There is **NO OPTION** to reschedule your surgery. We understand that emergency situations may arrive and that you may need to reschedule your surgery; *in the event that you need to reschedule your surgery, you will be charged a \$650.00 rescheduling fee.*

If for any reason the day of your surgery your blood pressure is elevated, your surgery will be cancel and there will be a fee of \$650. We will not be able to reschedule your appointment until we have at least 2 weeks of blood pressure readings (those readings must be within the normal levels). **Patient's initials:** _____

Cancellation Policy: Please understand that Dr. Huertas must uphold these policies as we have an obligation to our patients who may have requested the same day. Also, there are numerous medical supplies that are ordered specifically for your surgery. *In the event a surgery is canceled for any reason or fail to attend on your scheduled surgery date, ONLY 50% of the money will be refunded back to you.* **Patient's initials:** _____

By placing my signature below, I certify that I have read and understand the contents of this form.

Patient Signature

_____/_____/_____
Date