



Cosmetic & Plastic Surgery

RECONSTRUCTIVE & PLASTIC SURGERY | SCL Physicians

6500 West 104th Ave Ste 240
Westminster, CO 80020
303-403-7350

Patient Registration Form

Date: _____

____ Male ____ Female

Name (First, MI, Last) _____

Date of Birth _____ Age _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____

E-mail _____

Emergency Contact Information:

Name: _____ Home Phone: _____

Cell Phone: _____

Referred by: _____

I **AUTHORIZE** William L. Saber, M.D to release and/or obtain any necessary documents from my file to any involved healthcare/treating providers.

Signature _____ Date _____



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Medical History Questionnaire

Patient Name _____ Date _____

Primary Physician _____ Referring Physician _____

HT _____ WT _____ Is your general health good? Yes No

Are you allergic to or have you ever had a reaction to any medication, drug, or anesthetic? _____ Yes No
(Novocaine, Xylocaine, Iodine, tapes, lotions, soaps, etc.) Please list: _____

Have you ever had an operation or been hospitalized? Yes No
If so please list and date

Have you ever had rheumatic fever, heart trouble, heart murmurs, heart valve problems, palpitations, irregular heartbeat, chest pains, shortness of breath, angina, or swelling of the ankles?
If yes, circle specific disorder. _____ Yes No

Have you ever had high blood pressure, anemia, blood disorders, blood clots, strokes, or fainting spells?
If yes, circle specific disorder. _____ Yes No

Have you ever had diabetes, arthritis, cancer, thyroid disorders, stomach ulcers, kidney problems, asthma, lung or bronchial disease or any other serious illness?
If yes, circle specific disorder. _____ Yes No

Have you ever had problems with hepatitis, IV drug use, HIV/AIDS exposure?
If yes, circle specific disorder _____ Yes No

Have you ever had a MRSA infection? _____ Yes No

Have you ever had any eye disease or trouble with dryness, soreness, burning, itching, or excessive tearing? **If yes, circle specific disorder.** _____ Yes No

Have you ever had depression, any psychiatric problems, a nervous breakdown, or been under the care of a psychiatrist? _____ Yes No

Do you have a problem with excessive scarring or have you ever formed a keloid after being cut? _____ Yes No

Do you or any member of your family bruise easily or have any difficulty with prolonged bleeding When cut or after having a tooth extracted? _____ Yes No

Do any diseases run in your family? If so, please list: _____ Yes No

Date of your last physical exam: _____ Name of M.D. _____
Was everything O.K.? Yes No

Do you smoke, chew tobacco or use nicotine products? If so, how much? _____ Yes No
If you quit, when? _____

Do you drink alcohol? If so, how much? _____ Yes No

Illicit drugs can cause a dangerous and possible deadly reaction with anesthesia.
Do you use any type of illicit drugs (amphetamines, barbiturates, opiates, cocaine, marijuana, etc.) ? _____ Yes No

Have you ever had a cold sore? Yes No

Have you ever been prescribed ACCUTANE? Yes No



PERMISSION TO COMMUNICATE PROTECTED HEALTH INFORMATION

1. I Grant permission to Cosmetic & Plastic Surgery to disclose health information of the following individual as specified below:

Patient Name: _____ Date of Birth: _____

2. I authorize the information to be disclosed as specified below:

- On my voicemail/answering machine at home _____ (specify phone #)
- On my voicemail/answering machine at work _____ (specify phone #)
- On my voicemail on my cell _____ (specify phone #)
- To the following member(s) or other person(s):

Name	Relationship	Phone Number
_____	_____	_____

Name	Relationship	Phone Number
_____	_____	_____

- Other: (not able to email results/information) _____

3. The type and amount of information to be disclosed is as follows: (Please check appropriate boxes)

- Laboratory results Medical instructions or advice
- X-Ray reports
- Prescription drug information
- Appointment information, including confirmation/cancelation of appointment and type of appointment.
- Do not leave any information on voicemail, attempt to contact directly

*I understand that this may include detailed personal medical information including medical services to be provided, notification that items such as refills are ready for pick-up, as well as any information listed in #3 above.

Signature of Patient or Authorized Person Representative
(Please attach applicable legal documentation of authority)

Date

This consent form will expire when revoked in writing by the patient/representative or in the case of a minor, on the date the minor becomes an adult under state law, whichever occurs first.

3455 Lutheran Parkway Suite 220
Wheat Ridge, CO 80033



NOTICE OF PRIVACY PRACTICES

Exempla Plastic Reconstructive and Aesthetic Surgery
3455 Lutheran Parkway, Suite 220
Wheat Ridge, CO 80033

ACKNOWLEDGEMENT FORM

The attached form describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

I have received the Notice of Privacy Practices (HIPPA packet)

Name: _____

Signature: _____

Date: _____

This consent form will expire when revoked in writing by the patient/representative or in the case of a minor, on the date the minor becomes an adult under state law, whichever occurs first.



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I would like to receive information regarding Cosmetic, Aesthetcian and discounts offered by SCL Physicians Plastic, Reconstructive & Aesthetic Surgery.

- Please send information to my email address provided below:

Patient Name

Date

Patient Signature

This information will expire when revoked in writing by the patient