COSMETIC
Surgical Center
The doctor to trust for your beautiful new look

DIRECTIONS TO OUR OFFICE Coming South on Dallas North Tollway:

Travel South on the Dallas North Tollway Exit 635 East Exit Coit Rd. and turn right on Coit Turn Right on Forest Ln.

Turn Right on Park Central Dr. Turn Right into the Hospital Complex and Stay to your right We are in the last building on left **Building C Suite 612**

Coming South on 75 Central Expressway:

Exit Forest Lane (it is a joint exit that says Church Hill/Forest Lane) Exit and stay in the left lane coming down the service road You need to get over immediately to your right after the Church Hill loop Turn Right on Forest (this is your second traffic light) after you have exited the highway When on Forest look for hospital to your right make a Right turn on Park Central Ln. Turn Right into the hospital and stay to your right. We are in the last building on your left **Building C Suite 612**

Coming from the West TX area- Ft. Worth, Arlington, Grand Prairie:

Travel East on **I30** until you come to down town Dallas Take exit 46, US-75 Central Expy McKinney Merge on to US-75 remain on 75 for 10miles Take exit 8A Forest Ln.

Turn Left on Forest Ln. Turn Right at the 2nd stop light "Park Central" (at this point you will see the Hospital) Turn Right into the hospital complex, stay to your right. We are in the last building on your left **Building C Suite 612**

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7777 Forest Lane, C-612
Dallas, TX 75230
(972) 392-3511
www.drrai.net
E-mail: drrai@drrai.net

PATIENT REGISTRATION

Today's Date _____

☐Mr.
☐Mrs.
☐Miss _____ /_____ /_____
First Middle Last

_____
Address Apt# City State Zip

_____ _____ May we call you at work? _____
Home Phone Cell Phone Work Phone

_____/ _____/ _____
Occupation Employer Employer Address

_____ and/or _____ / _____ / _____
Social Security # Drivers License # Date of Birth Marital Status

_____ / _____ / _____
Spouse's Name Spouse's Employer and Business Address Spouse's Work #

****

E-mail Address: _____

****

Were you introduced to our office by any of the following sources?

☐Friend or Family: _____ ☐Dr. Rai's Website

☐Facebook ☐RealSelf ☐Google+

☐ Other_____

****

ARE YOU INTERESTED IN FINANCING THE PROCEDURE? Yes☐No☐

****

NAME OF SOMEONE WHO CAN BE REACHED IN CASE OF AN EMERGENCY:

Name: _____ Phone: _____ or _____

Relationship to Patient: _____

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Surjit S. Rai, M.D.
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E-mail: drrai@drrai.net

HEALTH HISTORY

NAME: _____**AGE:**_____**HEIGHT:**_____**WEIGHT:**_____

Reason for consultation: _____

PAST MEDICAL HISTORY

Medical: Do you or have you had:

- ☐ Prolonged bleeding
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart trouble or disease
- ☐ Fainting or black out spells
- ☐ Shortness of breath/ chest pain
- ☐ Ulcer
- ☐ Heart murmur/ irregular pulse
- ☐ Any other significant illness
- ☐ If so, what _____

Surgical:

Previous Operations	Date	Problems with Surgery/Anesthesia
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: Are you allergic to or have reactions to medications, drugs, local anesthetics?

Medication	Type of Reaction When Medication Taken
_____	_____
_____	_____

Medications: Medications taken regularly (including **aspirin** and **birth control pills**):

Medication/Dosage/Frequency	Medication/Dosage/Frequency	Medication/Dosage/Frequency
1.) _____	3.)_____	5.) _____
2.) _____	4.)_____	6.) _____

Bleeding/Transfusions:

HAVE YOU TAKEN APSIRIN OR DRUGS CONTAINING ASPIRIN IN THE PAST TWO WEEKS?

☐ Yes ☐ No

Do you or any members of your family have problems with prolonged bleeding after dental procedures or when cut?

☐ Yes ☐ No

Have you had any blood transfusions?

☐ Yes ☐ No If yes, any reactions? _____

Scarring: Have you had problems with excessive scarring?

☐ Yes ☐ No

PERSONAL HISTORY

Occupation: _____

Do you smoke? ☐ Yes ☐ No If yes, number of packs per day: _____

Do you drink alcohol? Never ☐ Occasionally ☐ Regularly ☐

Amount per day? _____

Do you take any drugs other than those listed previously? Yes No

If so, please list: _____

FAMILY HISTORY

Is there a history of any of the following in your immediate family? If so, list family member beside disease:

- ☐ Diabetes_____
- ☐ Hepatitis_____
- ☐ High blood pressure_____
- ☐ Stroke_____
- ☐ Heart attack_____
- ☐ Cancer (type) _____
- ☐ Tuberculosis_____

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PATIENT CONSENT FOR USE OF CREDIT CARDS, DEBIT CARDS, AND FINANCING

DISCLOSURE OF PROTECTED HEALTH INFORMATION

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am consenting to allow Cosmetic Surgical Center to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

If you agree to accept the terms of this consent:

Please initial each the following statements:

_____ (**Initial**) I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

_____ (**Initial**) I agree that this non credit card challenge agreement is irreversible.

_____ _____ _____

Print Patient's Name Date Signature of Patient of Legal Guardian

If you choose not to accept the terms of this consent, please read/sign below:

I have read and understood this consent; however I refuse to accept the terms. I understand that by refusing to sign, Cosmetic Surgical Center will only accept payment in the form of cash and/cashier's check from me

_____ _____ _____

Print Patient's Name Date Signature of Patient of Legal Guardian

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CONSENT FOR USE OF E-MAIL AND/OR TEXT COMMUNICATIONS

To serve you better, we have established an e-mail address and a way to text message. These will be used for communications about routine matters between our office and you. So please feel free to contact us at drrai@drrai.net. Remember, however, that this form of communication is **not appropriate for use in an emergency.** The turn around time for routine patient communications is 3-5 days, so use this form only for requests that do not require an immediate response. **Should you require urgent or immediate attention call us via telephone.**

We would like to use email communications for the following reasons:

(1) Schedule appointments
(2) Non urgent questions
(3) To stay in touch
(4) Brochures
(5) Updates from the office

When sending an e-mail, please put the subject of your message in the subject line. Also, be sure to put your name and return telephone number in the body of the message, so we can contact you directly.

We will use text message communications for confirming appointments only.

Communications relating to medical care may be filed in your medical record.

We are dedicated to keeping your medical record confidential. Despite our best efforts, due to the nature of e-mail and texting, third parties may have access to messages. When communicating from work, you should be aware that some companies consider e-mail and phone communication corporate property and your messages may be monitored.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors inherent to electronic messaging. Please be advised that your standards rates will apply to sending and receiving text messages.

I understand and agree to the above e-mail / text message policy.

Please check this box if you do not wish to receive text messages

_____ _____
Patient Signature Witness (optional)

_____
Date

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Patient's Name _____ **Date of Birth** ___/____/____
Last First Middle

Photograph Consent and Release

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of the Cosmetic Surgical Center medical staff.

I hereby give my consent for Cosmetic Surgical Center to use the photographs under one of the following circumstances.

Please initial one of the following:

_____ **Internet:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Cosmetic Surgical Center, can be used on the company's website in order to inform the public about plastic surgery methods. Further, I release and discharge Cosmetic Surgical Center, any employees of Cosmetic Surgical Center, and the American Society of Plastic Surgeons; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

_____ **All Media:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Cosmetic Surgical Center, can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Cosmetic Surgical Center, any employees of Cosmetic Surgical Center, and the American Society of Plastic Surgeons; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ **In Office Only:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Cosmetic Surgical Center, can be used in office for educational purposes only. Further, I release and discharge Cosmetic Surgical Center, any employees of Cosmetic Surgical Center, and the American Society of Plastic Surgeons; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Cosmetic Surgical Center. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Cosmetic Surgical Center.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

_____

Signature (Patient or Parent/Guardian if Patient is under 18) **Date**