DAUWE PLASTIC SURGERY

NAME_____ (MALE / FEMALE) AGE _____ DOB _____

REASON FOR CONSULTATION _____

HOME ADDRESS _____
street city state zip

MOBILE #_____ WORK # _____ INSTAGRAM @ _____

E-MAIL _____ OCCUPATION _____ EMPLOYER _____

HOW DID YOU HEAR ABOUT US? FRIEND DOCTOR INTERNET SOCIAL MEDIA

PLEASE LIST NAME OF REFERRAL SOURCE _____

WHICH OTHER PROVIDERS HAVE YOU CONSIDERED FOR THIS TREATMENT? _____

PREFERRED PHARMACY

PHARMACY NAME _____ NUMBER _____

PHARMACY ADDRESS _____

MEDICATION ALLERGIES_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PHYSICIAN NAME _____

OFFICE PHONE # _____ FAX # _____

PRACTICE ADDRESS _____

With my signature below, I hereby authorize the above stated office to forward my medical records to:
Dauwe Plastic Surgery
2801 Lemmon Avenue Suite 300
Dallas, TX 75204

SIGNATURE _____ DATE _____

PRINT NAME _____

DAUWE PLASTIC SURGERY

NAME OF PRIMARY INSURANCE COMPANY _____

POLICY NUMBER _____ GROUP NUMBER _____

NAME OF PRIMARY INSURED (*if other than the patient*) _____ DOB _ _____

RELATIONSHIP TO PATIENT (*circle one*) SPOUSE / PARENT / CHILD / OTHER _____

NAME OF SECONDARY INSURANCE COMPANY _____

POLICY NUMBER _____ GROUP NUMBER _____

NAME OF PRIMARY INSURED (*if other than the patient*) _____DOB _____

RELATIONSHIP TO PATIENT (*circle one*) SPOUSE / PARENT / CHILD / OTHER _____

ACKNOWLEDGEMENT OF PRACTICE POLICIES

Please scan the QR code to view the practice policies. By signing below you acknowledge that you have received and reviewed, understand and agree with the following practice policies:

1. **Notice of Privacy Practices.**
2. **Notice of Financial Policies.**
3. **Practice Policy for Surgical and Non-surgical procedures.**

If you have any questions, please speak with any member of the office staff.

SIGNATURE _____ DATE _____

PRINT NAME _____

DAUWE PLASTIC SURGERY

PHOTOGRAPH AND VIDEO DISCLOSURE AUTHORIZATION & RELEASE

I HEREBY GIVE PERMISSION to Dr. Phillip Dauwe and/or any Associate(s) or any assistant he may designate, to take photographs/videos of me or my body parts in connection with the plastic surgery procedure(s) to be performed by them and/or for diagnostic purposes. I agree that these photographs/videos will remain their property and a part of my permanent medical record.

I PROVIDE THIS AUTHORIZATION as a voluntary contribution in the interests of patient education. I understand that such photographs/videos shall become the property of Dr. Phillip Dauwe and may be retained and/or released by them for the purpose of including them in any print, visual or electronic media, specifically including, but not limited to publication in medical journals and textbooks, physician photo books, physician website, social media, or for the purpose of informing the medical profession, the general public, or a patient about plastic surgery procedures and methods. I understand that publication of these photographs/videos on the World Wide Web will render such photographs/videos visible on a worldwide scale.

It is specifically understood that I shall not be identified by name. However, I understand that in some circumstances the photographs/videos may portray features that will make my identity recognizable, such as facial features, tattoos, or birthmarks and that my identity may be disclosed in connection with the medical treatment I am undergoing.

I understand that after authorization, photographs and videos disclosed may not be undisclosed and are subject to permanent public exposure. However I understand that I have the right to request by written notice that such photographs and videos are no longer subject to further disclosure.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**").

RELEASE
I release and discharge Dr. Phillip Dauwe and all parties acting under their licenses and authority from all rights that I may have to the photographs/videos and from any claim that I may have relating to such use in publication or digital media, including any claim for payment in connection with distribution or publication of the photographs/videos.

I certify that I have read the above authorization and release, and fully understand the terms.

SIGNATURE _____ DATE _____

PRINT NAME _____

DAUWE PLASTIC SURGERY

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

REASON FOR CONSULT

_____ Last Mammogram: _____

_____ Current Cup Size: _____

_____ Desired Cup Size: _____

MEDICAL HISTORY

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SURGICAL HISTORY

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MEDICATIONS

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ALLERGIES **NKDA**

MED_____ REACTION_____

MED_____ REACTION_____

MED_____ REACTION_____

FAMILY HISTORY

MOTHER_____

FATHER _____

GRANDPARENTS_____

OTHER RELATIVE_____

SOCIAL HISTORY

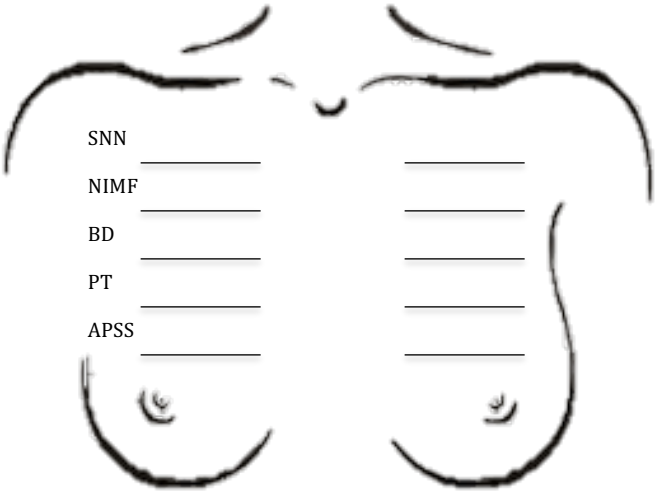
SINGLE / MARRIED / DIVORCED / WIDOWED

pregnancies _____ # children _____

Nicotine Use? **YES / NO / FORMER**

Quit day _____ Amount _____

PHYSICAL EXAM



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PLAN

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PHYSICIAN SIGNATURE _____ DATE _____