WEBER
FACIAL PLASTIC SURGERY

PATIENT INFORMATION

Name: _____

DOB: _____

Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____

Home Phone: _____

Email: _____

Preferred Method of Contact: _____

Occupation: _____

Employer: _____

FAMILY DOCTOR: _____

Office Phone: _____

PHARMACY NAME: _____

Pharmacy City: _____

Zip Code: _____

Major Cross Streets: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Cell Phone: _____

Home Phone: _____

HOW WERE YOU REFERRED TO DR. WEBER?

Doctor (Name): _____

Google RealSelf WeberFPS.com

Vitals Yelp Healthgrades

Friend WFPS Patient Other: _____

Name (Friend/ WFPS Patient): _____

PERSONAL MEDICAL INFORMATION

AGE: _____ HEIGHT: _____ WEIGHT: _____

MEDICAL CONDITION(S) – Please Circle

High Blood Pressure Heart Disease Diabetes

Kidney/ Liver Cancer Lung Disease

Sleep Apnea Anxiety Depression

Other: _____

Do you, or any family members, have a history of:

Easy Bruising: _____ Excessive Bleeding: _____

Anesthesia problems (high fever, slow to wake up)? _____

DRUG ALLERGIES? NO: ____ YES: ____

	DRUG(S)	REACTION(S)
1)		
2)		
3)		

	CURRENT MEDICATION(S)	DOSAGE
1)		
2)		
3)		

Do you take any medication(s) containing ASPIRIN?

NO: ____ YES: ____ Dosage: _____

PREVIOUS SURGICAL PROCEDURE(S)	Date(s)
1)	
2)	
3)	

Are you pregnant? NO: ____ YES: ____

Are you a smoker? NO: ____ YES: ____

If yes, how many packs per day: _____

If you have quit, for how many Months: _____ Year(s): _____

DO YOU DRINK ALCOHOL? NO: _____ YES: _____

If yes, how many servings per day: _____

I certify that the above information is accurate.

_____

Patient Signature Date

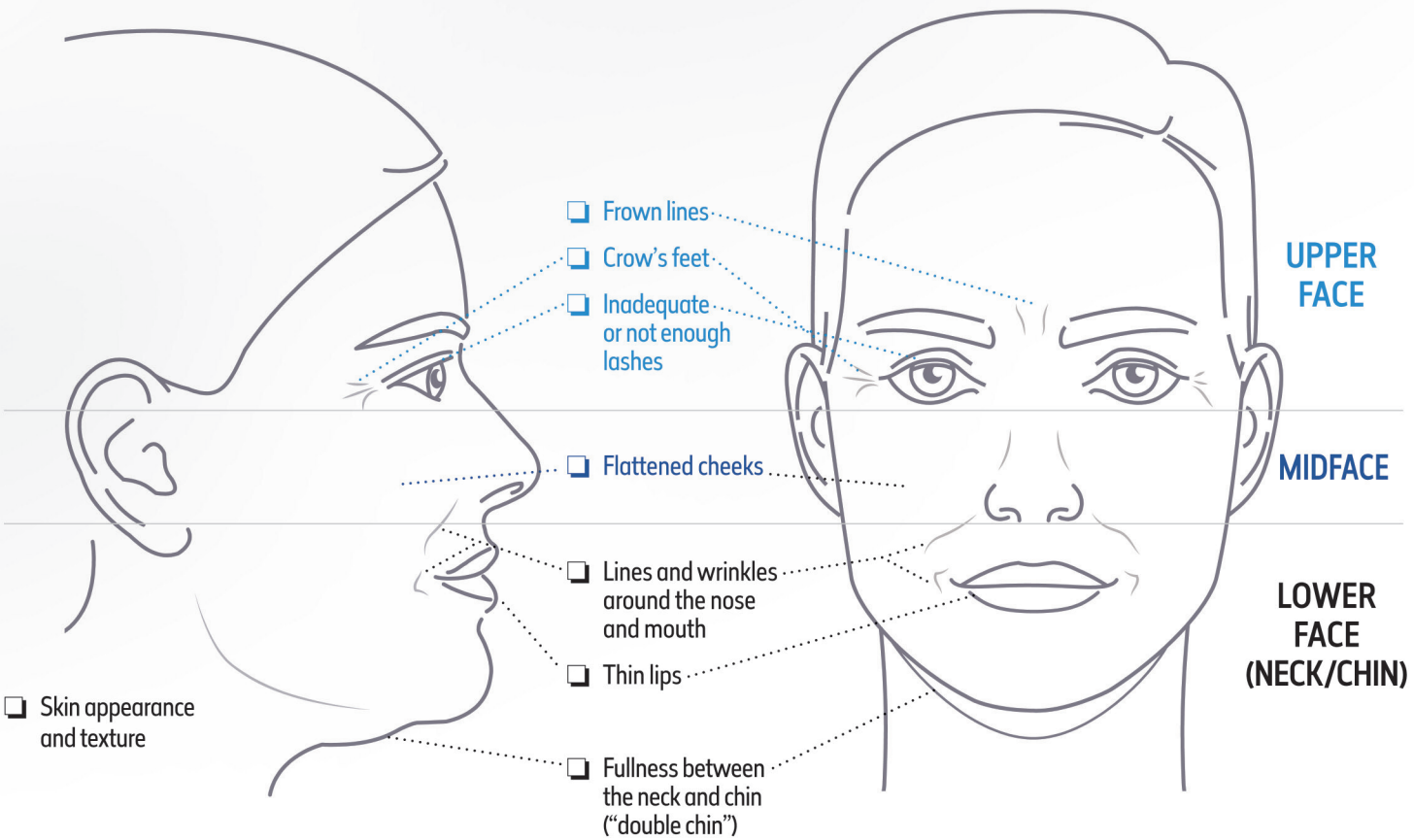
SELF-ASSESSMENT

NAME: _____ DATE OF BIRTH: _____ DATE: _____

What brings you in today? _____

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Office Notes

_____

_____

_____

_____

_____

Please complete and return this form to the front office before your consultation.

WEBER
FACIAL PLASTIC SURGERY

FINANCIAL POLICIES

At Weber Facial Plastic Surgery (WFPS), we are committed to providing you with the best possible care. Your clear understanding of our financial policies is important to our professional relationship. We are pleased to discuss the practice's professional fees with you at any time.

- If you are unable to keep a scheduled appointment with our office, please give at least 24-hour notice. Initial ___
- To reserve your surgery date, a scheduling and booking fee of 20% of the total surgical fee is required. This fee is refundable under the following circumstances:
  Cancellation of surgery at least 30 days prior to your surgery date – 100% refund
  Cancellation fewer than 30 days prior to your surgery date – Deposit is forfeited Initial ___
- If you reschedule your surgery fewer than 30 days prior to your surgery date a $1500 rescheduling fee will be assessed.
- The balance of any surgical, anesthesia or facility fees is due in full at your pre-operative appointment. Initial ___
- Dr. Weber's time, and that of his staff, is scheduled months in advance. If a medical or family emergency arises and your surgery must be postponed, please notify the office as soon as possible. Initial ___
- In case of a medical emergency, WFPS requires documentation for cancellation. Initial ___
- Fees for any additional medical expense (blood work, EKG, imaging, hospital admission etc.) are the responsibility of the patient and are not included in your surgery fee. Initial ___
- Quotes for surgical fees are valid for three (3) months. Initial ___
- There is a $55.00 charge for all returned checks.
- Should your account become delinquent, you will be responsible for all costs incurred for collection of your balance including any potential court costs and attorney fees. Initial ___
- WFPS does not contract with any insurance companies and does not bill insurance companies for any procedures. Initial ___
- The surgical fee includes twelve (12) months of routine post-operative care at WFPS. Initial ___
- WFPS DOES NOT provide refunds for any services performed. Initial ___

Thank you for taking the time to fully understand our financial policies. Please let us know if you have any further questions.

I certify that I have read, understand and agree to the policies and financial obligations outlined above.

Patient Signature: _____ Printed Name: _____ Date: _____

Witness Signature: _____ Printed Name: _____ Date: _____

WEBER
FACIAL PLASTIC SURGERY

REVISION PROCEDURES

Infrequently, a patient may require a revision procedure. Please review the details outlined below regarding revision surgery.

- If a minor, in-office, revision procedure is necessary within the first twelve (12) months, there will be a $1000.00 revision fee collected, provided that all post-operative instructions have been followed and all follow-up appointments attended as prescribed by Dr. Weber. Initial ___
- If any major revision procedure requires the use of the surgery center, the patient will be responsible for the $1000.00 revision fee in addition to any applicable facility and anesthesia costs. These expenses will be discussed with you in detail prior to scheduling revision surgery. Initial ___
- This stated policy applies to the twelve (12) months following your initial surgery. Revision surgery scheduled more than twelve (12) months following the date of your initial surgery will incur the entire surgery cost at the current WFPS surgical rates. Initial ___
- Revision fees will be collected at the time the revision procedure is scheduled. Initial ___

Thank you for taking the time to fully understand our revision procedure policies. Please let us know if you have any further questions.

I certify that I have read, understand and agree to the policies and financial obligations outlined above.

Patient Signature: _____ Printed Name: _____ Date: _____

Witness Signature: _____ Printed Name: _____ Date: _____

WEBER
FACIAL PLASTIC SURGERY

PHONE/ ELECTRONIC MESSAGE CONSENT

Dr. Weber and our staff may need to contact you. By filling out the information below, Weber Facial Plastic Surgery (WFPS) is better able to serve you and protect your privacy.

1) WFPS staff will NOT leave messages with anyone except the patient or legal guardian.
2) WFPS staff will NOT leave detailed messages by voicemail, answering machine, email or text message unless we have your written consent.

Please read below and consider carefully who should have access to your medical information.

I, _____, give Weber Facial Plastic Surgery permission to contact me regarding medical care, account information or promotional information. I understand that this consent can be revoked at any time in writing.

Communication Source	Leave a message?	Pertinent Information
Cell Phone	Yes / No	
Home Phone	Yes / No	
Text Message	Yes / No	
Email	Yes / No	
Other	Yes / No	

WFPS MAY SPEAK WITH THE PERSON(S) LISTED BELOW ABOUT MY MEDICAL CARE:

	Please Circle One	If yes, please list name below.
Partner	Yes / No	
Son or Daughter	Yes / No	
Friend/ Neighbor	Yes / No	
Other	Yes / No	

Additional Notes: _____

Patient Signature: _____ Printed Name: _____ Date: _____