JASON K. POTTER, MD, DDS

(214) 540-1420

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes Email _____

Age _____ Birthdate _____ SS# _____ Gender Female Male

Marital Status _____ Height _____ Weight _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____
Street & Suite # City State Zip

How did you hear about Dr. Potter?

TV News TV Ad Phone Book Magazine Newsletter Seminar Salon Web

Friend/Relative: _____ Doctor: _____ Other: _____

If you were referred by a specific person, may we thank them? Yes No

Emergency Contact: _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes $ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes $ _____

Insured: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Potter to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Potter and myself.

Signature _____ **Date** _____

*Please state your reason for today's consultation:

_____

Current and Past Medical History

Select any of the following medical conditions that apply:

- ☐ Adrenal Insufficiency
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Auto-Immune Disease
- ☐ Bipolar Disorder
- ☐ Blood Clotting Disorder
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes
- ☐ Easy Bruising
- ☐ End Stage Renal Disease
- ☐ Head Trauma
- ☐ Hearing Loss
- ☐ Hepatitis ____
- ☐ Hypertension
- ☐ Other

_____

_____

_____

- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Lung Cancer
- ☐ Lupus
- ☐ Lymphoma
- ☐ Malignant Hypertension
- ☐ Neuromuscular Disorder
- ☐ Paralysis
- ☐ Pneumothorax
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Treatment Date: _____
- ☐ Chemo Treatment Date: _____
- ☐ Renal Disorder
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Severe Reaction to Anesthesia
- ☐ Stroke
- ☐ Trauma
- ☐ Valvular Heart Disease

Medications

List all current medications and dosage:

_____
_____
_____

Allergies

List all allergies and reactions if known:

Herbal Medications and Supplements

Do you take any herbal medications or supplements?

◯ Yes ◯ No

Which herbal medications or supplements do you take? _____

Family History

Do you have a family history of breast cancer?

◯ Yes ◯ No

If yes, which relative(s)?

_____

Do you have a family history of Melanoma (skin cancer)?

◯ Yes ◯ No

If yes, which relative(s)?

_____

Gynecologic History

LAST MAMMOGRAM

Date: _____

Please provide our office with mammogram results

Past Surgeries

Have you had any surgeries on the following?

- ☐ Abdominal Wall: Hernia Repair
  Location: _____
- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Brain Surgery
- ☐ Breast Reduction
- ☐ Breast: Mastectomy
  Circle one: Right Left Bilateral
- ☐ Breast: Lumpectomy
  Circle one: Right Left Bilateral
- ☐ Cesarean Section
- ☐ Colon (Colectomy)
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Mechanical Valve Replacement
- ☐ Joint Replacement: Knee
- ☐ Joint Replacement: Hip
- ☐ Ovaries (Oophorectomy)
- ☐ Skin Cancer
- ☐ Spine Surgery
- ☐ Spleen (Splenectomy)
- ☐ Uterus (Hysterectomy)
- ☐ Other _____

_____

_____

- ☐ Plastic Surgery Procedures:

_____

_____

_____

_____

Skin Disease History

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Other _____
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
- ☐ None

Social History

Alcohol Intake:
- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more drinks per day

Smoking Status (please choose one)

- ☐ Current smoker
- ☐ Former smoker
- ☐ Never smoker

Start Smoking

Date: _____

Quit Smoking

Date: _____

Number of Packs per Day: ☐

Total Years Smoking: ☐

Preferred Pharmacy

Name: _____

Phone Number: _____

City or Zip Code: _____

JASON K. POTTER, MD, DDS **(214) 540-1420**

(Please Print Legibly & Fill In or Correct All Fields)

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, _____, authorize Jason K. Potter, MD, DDS and/or **[his/her/their]** representative(s), to take photographs, slides or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I understand and authorize the use of these images, without compensation to me, for the following specific purposes: office **photo album** for prospective patients; office **seminars** for prospective patients; on our **website** for prospective patients; in print **advertisements.**

Additional Comments:

I understand that:

1. Such photographs, slides or videotapes may be published by Jason K. Potter, MD, DDS in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Potter, for which Dr. Potter may be receive direct or indirect remuneration.
2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me.
3. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Potter and/or Jason K. Potter, MD, DDS, PA from all liability, including liability for negligence that in any way arises out of:

any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and

any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and certify that I have read this Authorization and Release carefully and fully understand its terms.

Signature _____ Date _____

Witness _____