BRYSON G. RICHARDS, MD
3860 S. Hualapai Way
Las Vegas, NV 89147
(702) 870-7070

NEW PATIENT INFORMATION SHEET

Patient Name: ______________________________

Parent or Legal Guardian: ______________________________

Address: ______________________________ Apt. #:______________

City: ______________________________ State: __________ Zip:______________

Home Phone: ____________________ Cell Phone: ____________________

E-mail Address: ______________________________

Sex: ____________ Date of Birth: ____________________Age: ______________

Employer: ______________________________ Occupation: ____________________

Emergency Contact Name/Phone#: ______________________________

Reason for Consultation Appointment: ______________________________

REFERRED BY: ______________________________

PATIENT MEDICAL HISTORY

NAME: ______________________________ DATE: ____________

* Have you ever had bleeding or clotting problems? ______________________________

* How many alcoholic beverages do you have per week? ________ * Do you smoke cigarettes? ________

* Do you smoke marijuana or hashish? ______________________________

* Do you take sedatives or related substances? ______________________________

* Do you have any known allergies to medications? ______________________________

* Do you have any allergies to any other substances? ______________________________

* Have you ever had a problem with anesthetics? ______________________________

* Do you have a history of Cold Sores/Herpes? ______________________________

* Have you recently traveled out of the U.S. or lived in concentrated housing? ____________________

* Have you ever had a T.B. Test, chronic cough greater than three weeks, bloody sputum, unexplained weight loss or night sweats? ____________

* List ALL present medications: (This Includes vitamins, herbs, prescription medications and over-the-counter drugs like aspirin etc ....)

____
____
____

* Have you had any serious illness? ______________________________

* Have you experienced any of the following?

__ HEART TROUBLE/HEART SURGERY ARTHRITIS
__ ARTHRITIS
__ ASTHMA/EMPHYSEMA
__ HEART MURMUR
__ ALLERGY
__ CHRONIC COUGH FOR MORE THAN 3 WEEKS
__ STOMACH ULCER
__ THYROID CONDITION
__ ANXIETY
__ DEPRESSION
__ ANEMIA
__ HEPATITIS/JAUNDICE
__ CONGENITAL HEART LESIONS
__ STROKE
__ DIABETES
__ HIGH BLOOD PRESSURE
__ EPILEPSY
__ TUBERCULOSIS
__ RHEUMATIC FEVER
__ KIDNEY DISEASE
__ CANCER

Signature: ____Date:______________

The web is becoming a key way patients learn about our practice. Do you participate in any of the following? (Check all that apply)

YELP ___ ***FACEBOOK ___*** ***TWITTER ___*** ***ANGIE'S LIST ___*** ***REALSELF ___***

BLOGGING: If yes, where can we see it? http://____

CONSENT TO BE PHOTOGRAPHED AND USE OF PHOTOGRAPHS

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. These photographs are a permanent part of my medical records and will never be shown to anyone else without my consent. I understand that I will be photographed before and after my procedures. I hereby certify that I have read the foregoing and fully understand its meaning and effect. I hereby consent to be photographed by Bryson G. Richards, M.D. and his staff.

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. The Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Examination of the American Board of Plastic Surgery to protect patient privacy.

Signature: ____ Date: ____________

Witness Signature: _______________________________________ Date: ____________

For various reasons, Bryson G. Richards, M.D. is often asked to show before and after photos of patients. Many patients, happy with their results, have given permission to use their photos anonymously. We now ask that you do so as well. Every attempt will be made to represent all patients and Bryson G. Richards, M.D. accurately and with integrity and dignity in all media. Please consider the following and initial the paragraphs you consent to:

*I recognize that prospective patients, such as myself, will ask to look at before and after photographs in the process of choosing a surgeon and evaluating specific procedures. I authorize the anonymous use of my photographs for this purpose by Bryson G. Richards, M.D.

Initial: ______

*I authorize the anonymous use of my photographs by Bryson G. Richards, M.D. in seminars, health fairs and conferences for interested and/or prospective patients.

Initial: ______

*I authorize the anonymous use of my photographs by Bryson G. Richards, M.D. for publication in medical journals, magazines, newspapers or programs produced for cable TV so long as I am notified in writing of such use prior to publication or production.

Initial: ______

*I authorize the anonymous use of my photographs by Bryson G. Richards, M.D. on the internet so long as I am notified in writing of such use prior to production.

Initial: ______

PREAMBLE

We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcomes of their treatments. We also recognize that in these instances, a patient has every right to pursue legal action if he/she feels we have been negligent in some way. We respect every patient's rights to do so.

While some healthcare legal claims are justified, there are also frivolous legal claims filed in our country - claims that are driving up insurance rates and impacting court decisions for the patient who truly deserve compensation. We believe that an agreement early in the treatment process regarding the use of board-certified experts will help expedite resolution of concerns.

OUR COMMITMENT TO YOU

We commit to using only American Board of Medical Specialties (ABMS) board-certified expert medical witness(es) in any legal situation, who follows the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics.

We demonstrate this commitment to you with our signature on the attached form.

WHAT WE ARE ASKING YOU TO DO

We are asking you or any representative to commit to this process also, by using only board-certified physicians expert medical witness{es) if you are dissatisfied with your medical care and decide on legal action.

We hope, and believe, you will never have to consider this again. But if you do, we will honor this commitment to you.

Bryson Richards, MD

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HIPPA Privacy Regulation

Acknowledgement/Consent

I authorize *Bryson Richards, MD* to use or disclose my protected health information and all other information necessary to carry out treatment or obtain payment. (Medical doctors, specialists, collections agencies, insurance companies).

________I authorize the release of information regarding my treatment to my spouse and/or significant other.

List any family members, relatives and/or friends that may discuss or request your medical information/records.

Name:	Relationship:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

________I do NOT want any of my information disclosed to family, relatives or friends without my written consent.

Signature: ______________________________ **Date:** ____________________

Print Name: ______________________________