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

NEW PATIENT INFORMATION SHEET

Patient Name: _____ Date: _____

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: _____

Emergency Contact Phone#: _____

Pharmacy Name: _____ Phone: _____

Reason for Consultation Appointment: _____

REFERRED BY: _____

PATIENT MEDICAL HISTORY

* 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? _____

*Are you pregnant or Nursing? _____ Date of your last menstrual cycle? _____

* Have you ever had a problem with anesthetics? _____

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

* Do you have any Communicable Diseases? _____

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

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

* Have you had any serious illness? _____

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

_____

* 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 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*** ___

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: _____

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: _____

Bryson Richards, MD

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HIPAA 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.

Print Name: _____

Signature: _____Date: _____