



NEW PATIENT INFORMATION

Legal Name _____

FIRST MIDDLE LAST

Preferred Name _____

FIRST MIDDLE LAST

Date of Birth: ____ / ____ / ____ Gender of Identification (circle) Male Female Neutral Gender Identified at Birth _____

Parent's Name (for minors) _____

FIRST MIDDLE LAST

Home Address _____

City / State / Zip Code _____

Mailing Address _____

PLEASE INDICATE IF THIS ADDRESS IS THE SAME AS ABOVE

City / State / Zip Code _____

Can we occasionally send you event invitations or specials? Yes No

Phone numbers / Email

CELL (____) _____ - _____ HOME (____) _____ - _____ WORK (____) _____ - _____

OTHER (____) _____ - _____ EMAIL _____

May we use the above telephone number/s and email address to contact you? Yes No

If not, what telephone number/s or email address/es may we use?

OTHER (____) _____ - _____ EMAIL _____

Employed by _____ Occupation _____

Spouse's name _____ Occupation _____

How were you referred to our office?

Patient or Physician _____

Other _____

Please check all items that played a role in your decision to visit us:

Google DrMosser.com AzalaSF.com GenderConfirmation.com Real Self Yelp Other _____



Health Insurance Coverage (necessary to schedule all types of surgery): _____

PROCEDURES

Please mark areas you would like to discuss.

FACE

- Brow / Forehead Rejuvenation
- Eyelid Improvement
- Nose Shape or Size
- Face Lift
- Cheeks
- Lips (wrinkles or fullness)
- Chin (too large or too small)
- Neck (skin or fat excess)
- Injectable
- Medical Facials/Skin Care
- Permanent Makeup
- Tattoos

BREAST/CHEST

- Breast Augmentation
- Breast Reduction
- Breast lift
- Gynecomastia
- FTM Top Surgery
- MTF Top Surgery

BODY

- Liposuction: (areas)
- Tummy Tuck
- Buttock Lift
- Lower Body Lift
- Thigh Lift
- Body Masculinization
- Body Feminization

RECONSTRUCTIVE

- Breast Reconstruction
- Mole Removal
- Scar Revision
- Other (please specify) _____

What is your greatest concern about undergoing plastic surgery?

How far in the future would you ideally like to have your surgery? 2 weeks 4-6 weeks 3-6 months 1 year



MEDICAL HISTORY

Age: _____ Current height: _____ Current weight: _____ Lifetime highest weight: _____

Do you smoke? Yes No If so, how much? _____

Do you use alcohol at all? Yes No If so, how often and how much? _____

Do you use recreational drugs? Yes No If so, what type? _____

Please list all medications you're currently taking (please specify what the medication treats & the dosage): _____

Medication allergies: list medication and specific reaction/s): _____

Have you had previous plastic surgery? Yes No

If so, please list all previous plastic surgeries (please list with dates): _____

Have you had any other surgeries? Yes No Please list _____

Have you ever had any difficulties with anesthesia? Yes No

Name of personal physician _____

Are you currently seeing a therapist? Yes No Therapist's name _____

FOR FEMALE BREAST & BODY CONSULTS

of Pregnancies _____ # of Births _____ Bra size (ex: 32A, 34C) _____



MEDICAL HISTORY

Please indicate if you have ever had any of these issues unless "current" is indicated.

	YES	NO
GENERAL		
Do you take nutritional / herbal supplements? Specify:		
Are you currently pregnant or lactating?		
Have you ever had any difficulties with anesthesia?		
Are you allergic to local anesthetics (ie. Lidocaine)?		
HEART/LUNGS		
High blood pressure		
Heart disease		
Lung disease		
NEUROLOGICAL		
Seizure disorder		
Epilepsy		
Bell's palsy		
Other neurological disease		
BLOOD		
Blood clotting abnormalities		
Excessive bleeding following surgery, nosebleeds, etc.		
Regular aspirin use		
	YES	NO
KIDNEY/LIVER		
Hepatitis		
Kidney disease		
ENDOCRINE		
Thyroid imbalance		
Hormone imbalance		
Menopause		
PCOS (polycystic ovarian syndrome)		
Diabetes		
IMMUNE		



Autoimmune disease Specify:		
Herpes (cold sores or shingles)		
Immunocompromised conditions		
HIV positive		
Cancer		
Other immune system issues		
SKIN		
Skin Cancer		
Rosacea		
Keloid scarring		
Current acne issues		
Melasma		
Skin infections (staph, MRSA)		

CONFIDENTIAL CHANNEL COMMUNICATION REQUEST

You have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____, hereby request the use of the following confidential channels for the communication of information related to my personal health or treatment. This request supersedes any prior request for confidential channel communications I have made.

May we discuss pertinent information with anyone else? Yes No

If yes, please state name and relationship to you.

Name _____ Relationship _____

Name of Patient _____

Signature _____ Print _____

(legal guardian's signature if minor) _____

Date: _____ Witness: _____



Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends.
3. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
4. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the office of Scott W. Mosser, MD.
5. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the office of Scott W. Mosser, MD. You must provide us with a reason that supports your request for amendment.
6. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the office of Scott W. Mosser, MD at (415) 398-7778 for further information. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to provide an authorization for other uses and disclosures. The practice of Dr. Scott Mosser, MD will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
9. If you have any questions regarding this notice or our health information privacy policies, please contact the office of Scott W. Mosser, MD at (415) 398-7778 for further information.

I hereby acknowledge that I have been presented with a copy of the office of Scott W. Mosser’s Notice of Privacy Practices.

Name of Patient _____

Signature _____ Print _____

(legal guardian’s signature if minor) _____

Date: _____ Witness: _____