Patient Information Sheet

Patient's Name: (first)_____ (mi)_____ (last)_____ **Date of Birth:**_____

Address: (street)_____ (city)_____(state)_____(zip code)_____

Would you like to be on our mailing list? Yes___ No___ Email Only___

How did you hear about us? _____

Social Security No.: _____ **Sex:** M F **Marital Status:**_____ **Preferred Language**_____

Home Phone: _____ **Business Phone:** _____ **Cell Phone:** _____

Would you like appointment reminders via text message? Yes___ No___

Email address:_____

Employer: _____ **Occupation:** _____

Employer's Address: _____ **Primary Care Doctor/Phone:**_____

Spouse's Name: _____**Spouse's Employer:** _____

Employer's Address(Spouse's**):** _____ **Business Phone(**Spouse's**):** _____

Name of a Nearest Friend or Relative not living with patient: _____

Relationship: _____ **Home Phone:** _____ **Business Phone:** _____

Name of emergency contact: _____**Emergency Contact Phone Number:** _____

I hereby give my permission for Dr. Robert L. Peterson, and his assistants to take photographs for diagnostic and record keeping purposes. It is specifically understood that in any such use I shall not be identified by name. I understand that Athena Clinics will make every reasonable effort to maintain my privacy. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgement. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy. By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.
By signing this form you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

_____ _____ _____

Signature: Patient or Legal Guardian **Print Name: Patient or Legal Guardian** **Date**

MAHALO FOR YOUR COOPERATION IN PROVIDING US THIS COMPLETED INFORMATION

Athena Clinic

Request for Services from Dr. Peterson

Name _____

We offer many services, ranging from quick fixes to major renovations. Please help us guide you in deciding which choices best suit your needs.

- What is your purpose for consulting Dr. Peterson? **Type of Procedure**_____

  - ☐ Information only
  - ☐ Second Opinion
  - ☐ Medical Evaluation
  - ☐ Planning surgery- If so, when were you planning to have surgery?_____
  - ☐ Other: _____

- Have you ever had any surgery before? When? _____
  Why?_____
  Outcome?_____

- Treatment always carries risks. What benefit do you expect to achieve from treatment that make it worth these risks? _____

- Recovery is important for healing. How much time can you devote to healing?
  - ☐ As long as it takes for best results.
  - ☐ A limited time, _____, but I can take longer if I need to.
  - ☐ I only can take this amount of time _____. I would like Dr. Peterson to limit surgery to give me the best chance of getting back to work on time. I realize that this will compromise the results that can be achieved.
  - ☐ Other:_____

- Cosmetic surgery, like all surgery, is expensive. How important is expense to you?
  - ☐ I want the very best result, no matter how much it costs.
  - ☐ I am willing to compromise results to save money.
  - ☐ My budget is limited. What would be the best choice within this range?
    - ☐ $100-$500
    - ☐ $500-$1000
    - ☐ $1000-$3000
    - ☐ $3000-$7000
    - ☐ $7000-$10,000

- Perfection is, of course, impossible to achieve. What changes are you hoping to achieve?

  _____
  _____

- Special things that we need to know about you in order to take good care of you (medical, religious, social, etc:

  _____
  _____

- Do you have any Allergies? _____