SCOTT W. MOSSER, M.D.
PLASTIC SURGERY

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

AZALA
MEDICAL AESTHETICS

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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) ____________________

SCOTT W. MOSSER, MD - A PROFESSIONAL MEDICAL CORPORATION
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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)		

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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
I
f yes, please state name and relationship to you.

Name____Relationship____

Name of Patient____

Signature____Print____

(legal guardian's signature if minor) ____

Date:______________________________________Witness: ____

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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: ________________________