DR. GREGORY C. ROCHE

BLOOMFIELD LASER & COSMETIC SURGERY CENTER

NEW PATIENT FORM

Referred By: (circle one) WRIF/DREW MIKE PODCAST, 95.5, Style, HOUR, Metro Times, Newspaper, Friend, Patient, Word of mouth, Doctor, Website, Google, Yahoo, Cosmetic, DOC Shop, Groupon, Other: _____

Facebook: _____ DONT FORGET TO "CHECK IN"

Last Name: _____ First Name: _____

Home: _____ Cell Phone: _____

Providing your number gives us permission to text you.

E-Mail: _____ Spouse E-Mail: _____

*To subscribe to our mailing list and receive exclusive offers *To email gifting ideas and offers

Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status (circle) S M D W

Date of Birth: _____ Sex: _____ Age: _____

Occupation: _____ Employer: _____ Work #: _____

Spouse's Name/Occupation: _____

Family Physician: _____ Phone #: _____

What Procedure(s) are you interested in? _____

Have you seen another doctor about this? (Circle) YES NO

If so, what happened with this doctor? _____

When are you thinking of having this procedure? ( ) ASAP ( ) 1-3 weeks ( ) 4-8 weeks
( ) 2-6 months ( ) Just here for a price quote

What information will most help you decide on the Physician, Staff, and Facility to do your surgery?
( ) Reputation ( ) Confidence ( ) Trust ( ) Safety ( ) Quality ( ) Results
( ) Convenience ( ) Experience ( ) Price ( ) Facilities ( ) Board Certification

Proposed Method of Payment: Cash _____ Check _____ Visa/MasterCard _____ Loan _____

Person to notify in case of Emergency:

Name: _____ Phone #: _____

Relationship to you: _____

As a Reminder, ***ALL previous balances are due at time of service. NO EXCEPTIONS!*** A fee of 18% interest will be charged on any balance not paid at the time of service or any balance not paid within 15 days of billing.

There is a cancellation fee of $40.00 if you don't inform the office of your cancellation within 24 hours of your scheduled appointment, unless there are extenuating circumstances.

I acknowledge that I am responsible for all the charges for services rendered to me.

PATIENT SIGNATURE: _____ DATE: _____

COMMENTS: _____

MEDICAL HISTORY

HEIGHT: _____ WEIGHT: _____
BMI: _____

Answer all that apply:

Have you ever had Plastic/Cosmetic Surgery in the past? YES NO

If so, what procedure, when, and by whom _____

What specifically would you like to have corrected? _____

Do you suffer from any of the following: Red/dark spots Fine lines Vascular/Roscea Unwanted Hair Skin Laxity

Decreased Vaginal Health Other: _____

How long have you been considering Cosmetic Surgery? _____

Medical Information:
Please answer all of the following:

Do you have an advance directive? YES NO

Allergies to any Medications: _____

Latex allergy? _____ Allergy to eggs? _____ Allergy to shellfish? _____

Medications Currently Taking: _____

Medical Conditions: _____

Have you ever been exposed to MRSA? _____

Past Surgical Operations: _____

Complications with previous operations or anesthesia? _____

(If so, explain) _____

Have you been tested for HIV? If so, when? _____

Is there any possibility you could be pregnant? _____ Have you been exposed to Covid : _____

How Often Do You:

A) Drink Alcohol?	Never	Occasionally	Often	Everyday
B) Use Tobacco?	Never	1 pack/week	1 pack/day	More
C) Use drugs?	Never	Occasionally	Often	Everyday
D) Drink coffee?	Never	Occasionally	1-2 cups/day	1 pot/day
E) Drink Tea?	Never	Occasionally	Often	Everyday
F) Drink water?	Never	Occasionally	Often	Everyday

G) Do you eat regular meals? YES NO

Family History:
Circle any medical conditions in your immediate family:

Diabetes	Cancer (if so, what type : _____)		Asthma
High blood pressure	Tuberculosis	Hepatitis	Hyper/Hypothyroidism
Hay Fever	High Cholestrol	Heart Disease	Depression
Anxiety Seizure disorders	Anemia	Malignant	Hyperthermia
Multiple Sclerosis	Hernia	Crohn's Disease	GERD (Heartburn)
Lupus	HIV/AIDS	Migraines	Sleep Apnea/Sleep Disorders
Covid-19			

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APPOINTMENTS: Scheduling is planned to allow the correct time for each service. Please be on time to ensure your full appointment time. We require a 24- hour notice in the event of cancellation. **Due to the office being a fully Accredited Surgical Center, We ask that NO CHILDREN be brought into the office.**

LATE ARRIVALS: If you are late for your appointment time, your treatment may be shortened so we finish on time for the next patient. The fee for the treatment will remain the same.

YOUR NEXT APPOINTMENT: To insure availability and a convenient appointment, we recommend that you schedule your next visit before you leave.

TYPE OF PAYMENT ACCEPTED: Visa, Master Card, Discover, American Express, check, or cash. **PLEASE NOTE:** When using a credit or debit card, a 6% service fee will be added to the transaction amount.

GIFT CERTIFICATES: Gift certificates make great gifts and are valid for one year from the date of purchase. Gift certificates are the same as cash and are not refundable or redeemable if lost or stolen.

PRE-PAID LASER PACKAGES: We require a 24-hour notice in the event of a cancellation or rescheduling. **If you fail to attend your scheduled appointment, you WILL lose that treatment without being able to make it up.** These appointments are generally made a month in advance and scheduled accordingly. **No refunds or credits will be given!**

RESULTS: I understand that for my concerns to be properly addressed, I need to follow the guidelines presented for my specific treatment protocol. I understand medicine is a science and no guarantees are made. I will not post or publish any defamatory remarks about my treatment.

POST-OP APPOINTMENT: If you fail to arrive for your scheduled appointment, you will lose that appointment without being able to make it up.

HOURS: Monday- Friday, 8:30 a.m. - 4:00 p.m.

WHAT TO WEAR TO YOUR SCHEDULED APPOINTMENT: Please come ready for your appointments. Please wear comfortable, casual, and quick to remove clothing. Some services require you to change into a gown while other services you will remain in your clothing.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

43494 Woodward Ave. #101 Bloomfield Hills, MI 48302
drroche.com | 248.338.1110

IN GENERAL, THE HIPAA PRIVACY RULE GIVES A PATIENT THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION. THE PATIENT IS ALSO PROVIDED THE RIGHT TO REQUREST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF THEIR HEALTH BE MADE BY ALTERNATIVE MEANS, SUCH AS SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE INSTEAD OF THE INDIVIDUAL'S HOME.

PLEASE COMPLETE THE FOLLOWING:

_____ _____

Patient Name Date of Birth

I, _____, WISH TO BE CONTACTED IN THE FOLLOWING MANNER:
Patient Name/Parent or Guardian

___CELL PHONE_____
___OK TO LEAVE DETAILED MESSAGE
___LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

___HOME PHONE_____
___OK TO LEAVE DETAILED MESSAGE
___LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

___WORK PHONE_____
___OK TO LEAVE DETAILED MESSAGE
___LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

PREFERRED CONTACT METHOD FROM OUR OFFICE

___CELL PHONE ___HOME PHONE ___WORK PHONE

FOR WRITTEN COMMUNICATION FROM OUR OFFICE:

___OK TO MAIL TO MY HOME ADDRESS
___OK TO MAIL TO MY WORK ADDRESS
___OK TO FAX INFORMATION TO:_____

TO PROVIDE INFORMATION TO SPOUSES, SIGNIFICANT OTHERS COMPANIONS, PARENTS/CHILDREN, OR GUARDIANS, WE MUST HAVE WRITTEN PERMISSION. PLEASE STATE TO WHOM WE MAY GIVE YOUR PERSONAL HEALTH INFORMATION.

IT IS OK TO SHARE MY PERSONAL INFORMATION WITH THE FOLLOWING PEOPLE:

_____, SPOUSE/COMPANION/SIGNIFICANT OTHER/PARENT/CHILD/GUARDIAN

_____, SPOUSE/COMPANION/SIGNIFICANT OTHER/PARENT/CHILD/GUARDIAN

SIGNATURE:_____**DATE:**____/_____/_____

To schedule an appointment to be seen in the office it is required that you have a Covid-19 Nasal Swab test performed and resulted negative. We ask that the results be obtained as close to the scheduled appointment as possible. Please check with your lab of choice for result time frame.

When you come in for your in office appointment we require you to bring your completed Covid log.

If you are a surgery patient it is important and imperative to complete the Covid test so the results are in the office for review no later then noon the day before your scheduled surgery day. If your test results are not received we will reschedule your surgery and additional fees will apply.

The new office rules and protocols are to keep our patients and staff safe and healthy.

If you have any questions please contact a member of the staff or Dr. Roche at (248) 338-1110

Patient signature:_____ Date:_____