San Francisco Snoring

Michael R. Macdonald, M D

500 Sutter Street
Suite 430
San Francisco, CA 94102
sleepwell@sanfranciscosnoring.com

Sleep well
Live well

415.956.3223

Patient Information Form

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Carrier: _____

DOB: _____ Age: _____ Gender: _____

Social Security Number: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about our clinic?

- ☐ DrMMacdonald.com
- ☐ SanFranciscoSnoring.com
- ☐ RealSelf
- ☐ Google
- ☐ Patient Referral: _____
- ☐ Other: _____
- ☐ Facebook
- ☐ Twitter
- ☐ Yelp
- ☐ Yellow Pages (city): _____
- ☐ Friend / Family: _____
- ☐ Dr. Referral: _____
- ☐ Seminar: _____
- ☐ La Belle Spa: _____
- ☐ Beauty Network: _____
- ☐ Original Skin: _____

What is the nature of your visit?

SURGICAL		SKIN CARE	
☐ Eyelid Surgery	☐ Browlift	☐ Blotchy Skin	☐ Wrinkles
☐ Facelift	☐ Midface Lift	☐ Skin Resurfacing	☐ Age Spots
☐ Cheek/Chin Implant	☐ Liposuction	☐ Facial Veins	☐ Leg Veins
☐ Nasal Surgery	☐ Otoplasty	☐ Chemical Peels	☐ Excision & Scars
☐ Facial Rejuvenation:		☐ Skin Resurfacing	☐ Moles
INJECTABLES/FILLERS		**SNORING TREATMENT**	
☐ Botox / Dysport	☐ Restylane / Perlane	☐ Snoring Treatment	
☐ Juvederm	☐ Radiesse	☐ Obstructive Sleep Apnea	

Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

_____

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Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Insurance Information

If applicable, please state the name of your insurance company: _____

(Health information is released to your insurance company with your permission only.)

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

_____

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

	Have you or do you still have:	No	Yes	Description
2.	Asthma or Lung Disease	☐	☐	
3.	Migraine Headaches	☐	☐	
4.	High Blood Pressure	☐	☐	
5.	Heart Trouble	☐	☐	
6.	Hepatitis or Liver Trouble	☐	☐	
7.	Kidney Disease	☐	☐	
8.	Diabetes	☐	☐	
9.	Epilepsy or Seizures	☐	☐	
10.	Problem Scarring	☐	☐	
11.	Have you been advised to or had psychiatric care?	☐	☐	

12. Others Not Listed: _____

Patient Name: _____

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Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____
3. Do you have children? ☐ No ☐ Yes, how many? _____

Section IV: Family History

Please list any significant or relevant family medical problems:

_____

Section V: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

_____

Financial Policy

Cancellations: Please be advised that we have a cancellation fee of **$100** for missed appointments or cancellations not received 48 hours prior to your appointment. We understand that emergencies do arise; however we request at least 48 hour notice for rescheduling or canceling all appointments. Failure to do so may result in your account being charged. Informing us of your cancellation allows us to fill your reserved time. **NO SHOWS WILL BE BILLED THE CANCELLATION FEE.**

Treatments: All treatments, procedures or pre-paid packages are non-refundable. Packages must be used within one year from the date of purchase. Credit from pre-paid treatments, procedures and/or packages may be applied toward other forms of treatment(s) or product(s) only at management's discretion. Credit can only be given to and used by purchaser. **NO REFUNDS. EXCHANGES ONLY.**

Appointments: We recommend that you make your next appointment prior to leaving our office. This is particularly important if you are having a series of treatments over a defined period of time.

Arrivals: Please arrive for your appointment in our office on time. This ensures that you will receive the required amount of time you deserve for your treatment and helps us to not intrude on the following patient's reserved time.

I have read this questionnaire, I understand the cancellation policy and I have disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

Receipt of Notice of Privacy Practices

I have received a copy of Aesthetic Surgery Center's Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Patient Name: _____

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Consent to Communicate

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders				
☐ Email Medical Info				
☐ Email Marketing Info				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Page	-	-	☐	-
☐ Text Appt Reminders – if so, list cell carrier:				
☐ Text Marketing Info – if so, list cell carrier:				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

Patient Name: _____