



**SCOTT W. MOSSER, M.D.**  
P L A S T I C S U R G E R Y

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*(First) (Middle) (Last)*

Parent's Name (if patient is a minor): \_\_\_\_\_  
*(First) (Middle) (Last)*

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Business Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

How were you referred to Dr. Mosser? Internet (search engine or website): \_\_\_\_\_

Epi Center: \_\_\_\_\_ A Patient : \_\_\_\_\_ A Physician: \_\_\_\_\_

Yellow Pages: \_\_\_\_\_ Other: \_\_\_\_\_

Health Insurance Company (necessary to schedule all types of surgery) : \_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you had previous surgery? \_\_\_\_\_ Type of anesthesia: \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If so, how much? \_\_\_\_\_

Have you had any serious injuries? \_\_\_\_\_

Have you ever had? (Please circle each yes or no):

Tuberculosis	Yes	No	Kidney Disease	Yes	No
Cancer	Yes	No	Blood Disease	Yes	No
Heart Disease	Yes	No	Diabetes	Yes	No
Lung Disease	Yes	No	Epilepsy	Yes	No
Hepatitis	Yes	No	HIV Tested	Yes	No
Migraine Headaches	Yes	No	Result: _____	(Optional	Answer)

**PERTINENT PRE-OPERATIVE INFORMATION**

Do you have high blood pressure? \_\_\_\_\_ Treatment \_\_\_\_\_

Do you have heart trouble? \_\_\_\_\_ Treatment \_\_\_\_\_

Are you allergic to any drugs? \_\_\_\_\_

Do you take aspirin regularly? \_\_\_\_\_ Other Medications? \_\_\_\_\_

Have you ever had any difficulties with Anesthesia? \_\_\_\_\_

Have you ever had excessive bleeding, i.e. following surgery; nosebleeds, etc.? \_\_\_\_\_

Name of your personal Physician: \_\_\_\_\_

**A PROFESSIONAL MEDICAL CORPORATION**

450 SUTTER STREET, SUITE 1400 ~ SAN FRANCISCO, CA 94108 ~ TEL:(415) 398-7778 ~ FAX: (415) 398-7784 ~ CONTACT@DRMOSSER.COM



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Area(s) of your body you would like to discuss during this Plastic Surgery Consultation:

**Cosmetic Face Procedures:**

- Brow / forehead rejuvenation
- Eyelid improvement
- Nose shape or size
- Face Lift
- Cheeks
- Chin (too large or too small)
- Neck (skin or fat excess)
- Fillers (Restylane, Radiesse or Sculptra)
- Lips (wrinkles or fullness)
- Facial Fine Lines, Wrinkles or Folds/ Minimal

Downtime Treatments

**Cosmetic Breast Procedures:**

- Breast Augmentation
- Breast lift
- Breast Reduction

**Cosmetic Body Procedures:**

- Liposuction
- Tummy Tuck
- Buttock Lift / Brazilian Buttock Lift
- Lower Body Lift
- Thigh Lift

**Reconstructive Procedures:**

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

What is your greatest concern about undergoing plastic surgery?

What time frame are you considering? How far in the future would you ideally like to have your surgery? (circle one)

2 weeks

4-6 weeks

6 months

1 year

Are you interested in a free skin consultation at our Med Spa?





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- 5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- 6. To federal officials for intelligence and national security activities authorized by law.
- 7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- 8. For Workers Compensation and similar programs.

**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:** \_\_\_\_\_  
(please print)

**Signature:** \_\_\_\_\_  
(if minor Legal Guardian’s signature)

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

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