Petroff Center
17720 Jean Way, Suite 100
Lake Oswego, OR 97035
(503) 635-4886

Date: ________________________

Completion of this information in its entirety is required at time of visit

☐Mr. ☐Mrs. ☐Ms. ☐Dr.	NAME:		PREFERRED NAME:
ADDRESS: ☐ NO MAIL		CITY:	STATE:
ZIP:	SOCIAL SECURITY NUMBER:	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER	
DATE OF BIRTH: / /	SEX: ☐M ☐F	PREFERRED CONTACT NUMBER: ☐HOME ☐WORK ☐CELL	
Phone: ( ) ☐HOME ☐WORK ☐CELL ☐ O.K. TO LEAVE A MESSAGE WITH DETAILED INFORMATION ☐ LEAVE A MESSAGE WITH CALL-BACK NUMBER ONLY		Alt. Phone: ( ) ☐HOME ☐WORK ☐CELL ☐ O.K. TO LEAVE A MESSAGE WITH DETAILED INFORMATION ☐ LEAVE A MESSAGE WITH CALL-BACK NUMBER ONLY	

EMAIL ADDRESS: ____

**By providing my email address I authorize you to send me appointment reminders, patient information, newsletters and promotional emails about specials and events. I understand that I may unsubscribe at any time, and that you will never sell or share my email with any external entity.

REFERRAL SOURCE: ☐DOCTOR ☐ESTABLISHED PATIENT ☐INTERNET ☐NEWSPAPER ☐WORD OF MOUTH ☐ OTHER______________________________(PLEASE LIST)	**REFERRING PHYSICIAN:** ______________________________ TYPE OF VISIT: ☐INSURANCE ☐COSMETIC ☐SECOND OPINION ☐LEGAL	
☐ STAFF MAY SPEAK WITH: NAME: ________________________________ RELATIONSHIP: ____________________________	☐ I WOULD LIKE TO REQUEST THAT ALL MAIL BE SENT TO AN ALTERNATE ADDRESS: ____ ____	
****REQUIRED**** EMERGENCY CONTACT :	RELATION:	PHONE: ( )

EMPLOYMENT: ☐FULL TIME ☐PART TIME ☐FULL TIME STUDENT ☐PART TIME STUDENT ☐RETIRED ☐UNEMPLOYED	
OCCUPATION:	EMPLOYER/SCHOOL:

PETROFF CENTER NOTICE OF PRIVACY PRACTICES CONSENT

Recipient Authorization to Use or Disclose Protected Health Information

PATIENT RECORDS OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

The privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

I have read/received the notice of Privacy Practices Acknowledgment and have been provided the opportunity to review it as well as request a copy for my personal reference.

Name: ______________________________________ Date of Birth: ________________

Signature: ____________________________________ Date: ____________________

PAYMENT POLICY

Payment is due in full at the time of service for all office visits, ancillary services and product. We accept cash, check, VISA, MasterCard, American Express and Discover for your convenience. Financing is available through CareCredit.

The Petroff Center has a 30-day exchange policy for all product purchases.

Cancellation Policy

Life happens…should you experience a change in your availability, we are requesting that you notify our office before noon on the business day prior to your scheduled appointment. We would be happy to assist you with rescheduling. Your prompt notification helps to ensure that every patient has fair access to schedule a timely appointment.

Should you fail to show for your scheduled appointment or notify our offices of your cancellation, we reserve the right to charge the following:

Mark A. Petroff, MD		Spa Services	
New Patient Consultations:	$100	Spa Consultations:	$50
Injectable Appointment:	$340	Facial and/or Laser Services	50% of scheduled service

Insurance

Mark A. Petroff, MD PC and/or the Petroff Center are contracted to participate directly with the Medicare program only. Effective 9/30/11, we have elected to terminate our participation with our remaining insurance contracts. Our decision does not affect our ability to treat you for your condition. Our decision allows us to take a patient-centered approach and provide excellent patient care. We recommend that you contact your insurance plan for a complete description of your out-of-network plan benefits.

Late Fees

After 90 days from the date of service, all accounts are subject to a Finance Charge of 1.5% per month, which is 18% per annum.

Canceled Checks

A $35.00 NSF charge will be applied to my account for any checks returned for insufficient funds.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. All accounts assigned to collections will be charged a $150.00 collection fee. I hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize payment of insurance benefits directly to the Petroff Center. I authorize the use of this signature on all insurance submissions.

____
Signature of Patient (for patients over the age of 18)

____________________ ____
Date Signature of Guarantor or Legal Guardian (for patients under the age of 26)

PETROFF CENTER
Health Questionnaire

Mark A. Petroff, M.D. FACS

In order for us to fully understand your needs, we greatly appreciate you taking a moment to answer the following questions about your health and habits. Please answer each question to the best of your knowledge.

All information will be held in the strictest confidence.

Date: ________________

Name: ____ Age: _______ Height: _______ Weight: _______

Medical History: Please check applicable boxes

- ☐ Anemia
- ☐ Artifical Joints/Implants
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder/Bruises Easily
- ☐ Blood Clots
- ☐ Cancer
- ☐ Defibrillator
- ☐ Diabetes
- ☐ Eye Problems
- ☐ Epilepsy or Seizures
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Herpes Simplex/Cold Sores
- ☐ High Blood Pressure
- ☐ HIV/Aids
- ☐ Hormone Imbalance
- ☐ Infections
- ☐ Kidney Problems
- ☐ Liver Problems (including jaundice)
- ☐ Motion Sickness
- ☐ MRSA/Staph Infection
- ☐ Neck and/or Jaw Problems
- ☐ Neurologic Problems
- ☐ Pacemaker
- ☐ Radiation Therapy/Chemotherapy
- ☐ Sensitive Teeth
- ☐ Sleep Apnea/Snoring
- ☐ Stomach or Intestinal problems
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Other relevant medical history
- ☐ **None**

Additional comments if needed: ____

____

Are you being treated for any medical illnesses not listed above? ☐ No ☐ Yes

List: ____

____

Please list any operations that you have had (including minor and cosmetic surgeries: ☐None ☐Yes

List: ____

____

Any reactions to anesthesia: ☐ No ☐Yes: Explain: ____

Please list any hospitalizations that you have had (excluding surgeries): ☐None ☐Yes

List: ____

____

Past Non-Surgical Cosmetic Procedures (i.e. Botox, fillers, lasers): ___________________________________

____

Family History: Please check applicable boxes

☐ Hemophilia ☐ Malignant Hyperthermia ☐ von Willebrand ☐ Unknown (Adopted) ☐ NONE

Please list any medications (**with dosages**) you are taking (Including: aspirin, vitamins and herbal preparations): ☐None

List: ____

____

____

List all drug/food allergies and **reactions**: ☐None ____

____

____

Skin History: Please check applicable boxes

☐ Acne
☐ Bruising
☐ Pregnancy Mask/Melasma
☐ Dry Skin
☐ Eczema
☐ Hives or Itching
☐ Infection of the Skin
☐ Keratosis
☐ Melanoma
☐ Moles
☐ Psoriasis
☐ Rashes
☐ Scarring (Keloid-raised or hypertrophic-widened)
☐ Skin Cancer
☐ Sun Exposure (indicate last date in notes)
☐ Suspicious Lesion
☐ Tanning bed use
☐ Ulcers
☐ Warts
☐ **None**

Additional comments if needed: ____

____

Please describe your daily skin care regimen: ____

____

Social History

	YES	NO	Notes/Details
Do you drink alcohol? (if yes, indicate daily or socially in the notes)	☐	☐	
Do you use marijuana/CBD?	☐	☐	
Do you use recreational drugs? (if yes, list in the details)	☐	☐	
Tobacco, Snuff, Pipe, Cigar, and/or Vaping use?	☐	☐	

Skin Type (when exposed to the sun for about 1 hour with no protection) Please check applicable box

☐ Always burns, never tans
☐ Rarely burns, always tans
☐ Always burns, sometimes tans
☐ Brown, moderately pigmented skin
☐ Sometimes burns, always tans
☐ Black Skin

Patient Signature: ____ **Date:** _______________________