David M. Duffy, M.D.

NEW PATIENT INFORMATION FORM

Date_____ Home Phone (_____)_____ Email_____

Name_____ Age_____ Date of Birth_____/_____/_____

Address_____

Cell Phone (_____)_____ Are you a former patient of Dr. Duffy's?_____If Yes, what year?_____

Employer_____ Occupation_____Work Phone (_____)_____

Employer's Address_____

Nearest Relative_____ Phone (_____)_____City, State_____

Do you have MediCare?_____MediCare#_____Secondary Insurance Co. and #?_____

How did you find out about Dr. Duffy?_____Referred by:_____

Medical History

Describe the reason for your visit today. Your problem? Where is it located? How long have you had it? Have you had treatment before for it? What medication are you currently using for it?

_____

_____

_____

Are you currently under a physician's care for a **serious medical problem**? Describe_____

Recent **surgeries or hospitalizations**? When? Describe_____

List any **oral medications** you are currently taking._____

List any **allergies or reactions** to medications, either **topical or oral**._____

Have **you or any family member** had pre-cancer, skin cancer, or other cancers, or cancer surgery? Type of Cancer? Basal Cell? Squamous Cell? Melanoma?

_____

Have injuries to your skin ever healed with **raised scars, brown or white spots**?

Describe._____

Do you have a history of any of the following conditions? **PLEASE CHECK ✔ ALL THAT APPLY.**

❑ Diabetes	❑ Heart Problems	❑ Seizures	❑ Epilepsy	❑ Fainting	❑ Irregular Heartbeat
❑ Tuberculosis	❑ High Blood Pressure	❑ High Cholesterol	❑ Hepatitis	❑ Jaundice	❑ Ulcers
❑ Gastric Disorders	❑ HIV Positive	❑ Respiratory Issues	❑ Hives	❑ Hay Fever	❑ Asthma
❑ Eczema	❑ Cold Sores	❑ Rashes	❑ OTHER_____		

Chronic skin problems (list)_____

Serious Illnesses (list)_____

Are you currently **pregnant or nursing**?_____Do you plan to become pregnant?_____

Do you wear **contact lens**?_____Have you ever had an **adverse reaction to local anesthetic**?_____

For 30 years, Dr. Duffy's practice has been dedicated to cosmetic dermatology---the pursuit of healthier, more beautiful skin at any age. Because of this, we are happy to provide any information and services you desire on rejuvenating your skin. Please let us know if you have an interest in any of the following.

Other Items of Interest (OPTIONAL)

- ❑ Botox
- ❑ General Skin Rejuvenation
- ❑ Acne Breakouts
- ❑ Neck Rejuvenation
- ❑ Home Skin Care
- ❑ Rough Patches
- ❑ Silk Peels
- ❑ Hair Removal
- ❑ Tattoo Removal
- ❑ Lip Augmentation
- ❑ Wrinkles, Sun Damage
- ❑ FRAXEL Rejuvenation
- ❑ Hand Rejuvenation
- ❑ Sunscreen Advice
- ❑ Cracked Heels
- ❑ Rejuvenating Glycolic Peels
- ❑ Medical-Grade Facials
- ❑ Fillers
- ❑ Removing Unwanted Veins
- ❑ Irregular Pigment, Brown Spots
- ❑ Rosacea, Broken Veins on the Face
- ❑ Moles I'd Like Checked
- ❑ Liver Spots/Age Spots
- ❑ Loose Skin
- ❑ Resurfacing/Retexturizing
- ❑ Scars
- ❑ Other_____

Our website **www.drdavidmduffy.com** can provide you with lots of in depth answers to your questions, anytime you're ready.

If we are treating you with any of the lasers today, please read and respond to the Pre-Laser Treatment Questionnaire carefully. We will tailor the settings we use to treat you, based on the information you provide, so be as accurate as you can.

Pre-Laser Treatment Questionnaire

Have you used any of the following products on the areas to be treated today, in the past 5 to 7 days. Circle all that apply.

Aspirin or Ibuprofen	YES	NO	**Exfoliant Scrubs**	YES	NO
Retin-A	YES	NO	**Benzoyl Peroxide**	YES	NO
Glycolic Products	YES	NO	**Benzoyl Wash**	YES	NO
Alpha Hydroxy Products	YES	NO	**Chemical Peels**	YES	NO
Anti-Acne Products	YES	NO	**Shaved** (in the past 2-3 days)	YES	NO
Anti-Wrinkle Products	YES	NO	**Sun Exposure**	YES	NO
Salicylic Acids	YES	NO	**Suntan**	YES	NO

_____ Signature _____ Date _____ Staff Initials

David M. Duffy, M.D.
Board Certified Dermatologist
4201 Torrance Blvd • Suite 710 • Torrance, CA 90503
310 370 5670

David M. Duffy, M.D.
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Pre-Anesthetic Questionnaire

There is a window of opportunity following the use of local anesthetic in which the treated area is completely numb. For some patients this occurs quickly and disappears just as quick. Others must wait a few moments for anesthesia to occur.

Generally, your experience with dental anesthesia will tell you the category you belong in. We use lidocaine without epinephrine (adrenaline), which dentists often use to reduce bleeding and make anesthetic last longer. Adrenaline is responsible for most of the side effects associated with anesthesia (racing heart, apprehension and nausea). Nevertheless, some patients routinely faint. Usually as a consequence of fear or low blood sugar.

This questionnaire will help identify patients who are at risk of fainting and/or those difficult to numb.

WHEN VISITING THE DENTIST: (circle answers that apply)

Have you ever had a cold sore? YES NO
If so, where (i.e. upper lip, lower lip, corner of mouth, nose)

Are you afraid of needles? YES NO

Do you become numb: QUICKLY SLOWLY

How long does the numbness last? LONG SHORT

Have you ever passed out from an injection? YES NO

Does the adrenaline in anesthetic cause: RAPID HEARTBEAT ANXIETY NAUSEA

Have you eaten today? YES_____ NO
(What did you eat? At what time?)

THIS FORM IS REQUIRED BY FEDERAL LAW

David M. Duffy, M.D.
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PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, with whom we may speak to regarding your care and treatment:

   _____

   _____

2. Please list the family members or significant others, if any, whom we may contact ONLY IN AN EMERGENCY:

   Name: _____ Phone Number: (____)_____
   Name: _____ Phone Number: (____)_____

3. Please print the address of where you would like follow-up correspondence from our office to be sent:

   _____

   _____

4. Please print the telephone number where you want to receive calls about your appointments, lab results, etc.: (____)_____

   ***I am fully aware that a cell phone is not a secure and private line.**

5. Can messages regarding your appointments and follow-up visits be left on your telephone answering machine or voicemail?

   YES _____ NO _____

PATIENT NAME _____(guardian if under 18 years)

_____
PATIENT/GUARDIAN SIGNATURE DATE _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____

Physician's or Authorized Representative's Signature (Date)

DAVID M. DUFFY, M.D.

Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____

Patient's or Patient Representative's Signature (Date)

By: _____

Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(2-08)