James E. Murphy PLASTIC Surgery & MEDICAL SPA

PATIENT INFORMATION

Patient Name: _____
First **Middle** **Last**

Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____-_____-_____ DOB: _____/_____/_____ Age: _____

Marital Status :**(please circle one)** Single Married Divorced Widowed Sex: M F

Home phone: (_____) _____-_____ Work: (_____) _____-_____ Ext #_____

Mobile: (_____) _____-_____ E-mail: _____

Preferred contact: **(circle one)** Home phone Work phone Mobile phone E-mail

What are the cosmetic or non-surgical procedures that you are interested in?

_____

Emergency Contact:

Name: _____ Relationship: _____
First **Middle** **Last**

Address: _____
City: _____ State: _____ Zip Code: _____
Mobile: (_____) _____-_____ Work: (_____) _____-_____ Ext #_____

Employer Information:

Name: _____ Occupation: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Referral Source: (Please circle one)

Patient Doctor Magazine: Stroll Magazine Internet: nnpsa.com other: _____

Google: _____ Yahoo: _____ _____

If referred by patient or Doctor, please provided name: _____

Signature: _____ Date: _____

PATIENT HEALTH HISTORY

Name: _____ DOB: _____ Age: _____

Gender: M/F Marital Status: S M W D P Height: _____ Weight: _____lbs

Occupation: _____ High Level of education: _____

MEDICAL HISTORY

Do you currently have or have had in the past? (Check all that apply)

Condition	Yes	No	Condition	Yes	No
Aids(HIV)			Digestion (stomach Ulcers, heartburn, vomiting)		
Arthritis			Ears, Nose, Throat (hearing loss, sinus problems, sore throat		
Asthma			Eyes (glaucoma, macular degenerations)		
Anemia			Heart (murmur, pacemaker, chest pain, irregular heart beat)		
Blackouts/Fainting			Hepatitis		
Bladder/kidney problems			High Blood Pressure		
Bleeding problems			Breathing problems		
Blood clots			Neurologic (e.g., numbness, weakness, headaches, paralysis)		
Breast Cancer			Pregnancy		
Skin Cancer			Psychiatric Problems (e.g. depression, anxiety)		
Colon Cancer			Skin problems(e.g. rashes, excessive dryness)		
Lung Cancer			Sexually transmitted disease		
Prostate Cancer			Obesity		
Thyroid Cancer			Osteoarthritis		
COPD(emphysema)			Osteoporosis		
Coronary artery disease			Tuberculosis		
Diabetes			Thyroid disease		
Herpes/Cold sores			Keloid scarring		
Cirrhosis/liver problems			Digestive Issues		
Kidney Disease			Pancreatitis		

Please provide an explanation for any items for which you checked "Yes"

_____

_____

_____

SURGICAL HISTORY

Please list any surgeries, biopsy, mammograms, or history of breast cancer you have had, including plastic surgery. Please provide dates and any complications.

_____

_____

_____

Have you ever had any problems/complications related to anesthesia? Yes No
If yes, please explain:

_____

Is there any family history of problems related to anesthesia? Yes No
If yes, please explain: _____

SOCIAL HISTORY

Do you currently smoke? □ Yes □ No
If yes, how many per day? _____ How many years? _____

Do you or, have you in the past used illicit drugs? Yes N□ □
If yes, please explain _____

If you previously smoke, how long did you smoke? When did you quit?
_____
Do you drink alcohol/beer/wine? □ Yes □ No
If yes, how much? _____ How often? _____

Do you exercise? □ Yes □ No
If yes, what type of exercise/how often? _____
_____

Do you have children? □ Yes □ No
If yes, how many? _____

MEDICATIONS

Please list all medication including dosage and frequency (prescription and/or over the counter) you currently take and the condition for which it is taken.

Medication	Condition	Dosage	Times per day

Do you take aspirin, aspirin containing or non-steroidal medications routinely (including Motrin, Advil, Ibuprofen)? □ Yes □ No
If yes, which and how often? _____

Are you taking any supplements such as fish oil or herbal supplements? □ Yes □ No
If yes, which and how often? _____

_____

ALLERGIES

Are you allergic to any medications? □ Yes □ No
If yes, please list medication and reaction:

Medication	Reaction

Other allergies (such as food or latex): _____
Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____

MEDICAL APPOINTMENT CANCELLATION/LATE/NO SHOW POLICY

Thank you for trusting Murphy Plastic Surgery and Medical Spa with your care. When you schedule an appointment with Murphy Plastic Surgery and Medical Spa, we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 48 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

· Effective May 1, 2023 any patient who fails to show or **cancels/reschedules** an appointment and has not contacted our office with at least 48 hours' notice will be considered a No Show and charged a fee of:

$250.00 for Dr. James Murphy's services.
$100 for Tracy Murphy RN's services.
$65.00 for Aesthetician services.

Effective May 1, 2023 patients who are 10 minutes late will be considered a no show and charge the above no show fee as a result.

· After the first no show we reserve the right to require patients to prepay for upcoming appointments after the cancellation fee is paid.

· The cancellation fee is charged to the patient's credit card on file from initial appointment. If the credit card on file doesn't go through this will result in the inability to make another appointment until the fee is paid.

· Any new patient who fails to confirm their appointment 24 hours prior to appointment will be cancelled the day before their appointment and will need to reschedule. You may confirm by calling 775-322-3446 or texting the confirmation to that number.

· As a courtesy, when time allows, we make reminder calls or texts for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Murphy Plastic Surgery and Medical Spa Monday – Friday 9-5 or call after hours line at the main number 775-322-3446 to leave a message.

Credit card: VISA/Mastercard/AMEX/Discover/American Express
Card Number:_____**Expiration Date**:_____ **CVV**:_____Zip code:_____

I have read and understand the Medical Appointment Cancellation/Late/No Show Policy and agree to its terms. I agree to prepay for all of my appointments from today forward. If any of the above circumstances occur, I am forgoing my no show fee payment for that appointment in the prepayment. I agree to have the above credit card on file for the case of a cancellation/Late/No Show.

_____ Signature (Parent/Legal Guardian) and Date_____Print name

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorized the Doctor to release any medical information including diagnosis, X rays, test results, reports, and records pertaining to a treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: Diagnostic, insurance, legal, and at times when the doctor deems it necessary in order to ensure the best medical care of my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of information.

FINANCIAL AGREEMENT AND ACKNOWLEDMENT

I am responsible for payment at completion of service same day. We accept cash and credit cards but no checks. As of Jul 1st, 2025 Murphy Plastic Surgery will impose a surcharge of 3% on the transaction amount of Visa/ MC and all credit card products, which is not greater than out cost of acceptance. We do not surcharge Visa/MC debit cards, or any back debit cards, and prepaid cards. Surgery payments will be arranged by Dr. Murphy's Cosmetic Counselor. If there are a significant amount of no shows you may be asked to prepay when scheduling your appointment, which may be determined by staff. In the event legal action should become necessary to collect any unpaid balance, I agree to pay all collection fees and/or court costs and legal fees required. I hear by acknowledge that I have read, completed, and understand the Patient Information Form, Financial Policy, and Medical Records Release.

Signature: Date: / /

Murphy Plastic Surgery and Medical Spa
10401 Double R Blvd
Reno, NV 89521
775-322-3446
(You can text or send pictures from your phone to this number for any questions after treatment)
Fax: 775-418-9713
Website and store for Dr. Murphy Skincare: www.nnpsa.com

WEBSITE AND PHOTOGRAPHIC RELEASE AND CONSENT

I authorize my plastic surgeon and his office staff to use my photographs, videotapes and case information and testimonials in educational and scientific settings including lectures, and multimedia presentations for an audience of medical professional, at which members of the press may be present, and medical, surgical and scientific journal articles. In addition, this information could be posted on our website at www.nnpsa.com and www.nevadatattooremoval.com I understand and accept that I may be recognized from my likeness or case history. I authorize the use of my photographs, videos and case information in the following.

- Commercial / educational settings: my surgeon's office patient education material; my surgeon's file of pre and postoperative patient photographs available to prospective patients for viewing in the office; newspaper and magazine articles in which my surgeon's personal web site or web page; and lectures and multi-media presentations given by my surgeon for the general public.

- I also authorize my plastic surgeon's professional association, the not-for-profit American Society for Aesthetic Plastic Surgery, to use my photographs and case information in fulfilling its mission of public education, in any of the following settings: patient education brochures available for purchase; educational video tapes available for purchase; lectures and slide presentations available for purchase; information submitted by the Society to consumer periodicals; magazines and web sites for press or internet publication; television programs about plastic surgery; and case studies presented on the Society's web site at www.surgery.org

- Social Media. I authorize the use of my photographs and videos, taken in the office to be used to market the practice on social media, including but not limited to Instagram, Facebook, Snap Chat, and Twitter.

- This authorization expires only when the Patient informs the practice that he or she is no longer a patient of the practice, or would like that their pictures not be used.

- This authorization is voluntary. I have not received compensation for use of my photos or videos.

Please check one:

☐ **I authorize the use of my photos** ☐ **I decline the use of my photos**

_____ _____

Patient Signature/Date Witness Signature/Date

_____ _____

Print Name Print Name

_____ _____

Signature of Parent/Guardian Printed Name of Parent or Guardian