

Sara Wasserbauer, M.D., PC  
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PATIENT REGISTRATION

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

Social Security # \_\_\_\_\_ (Required for Surgery Only)

Cell Phone # \_\_\_\_\_

Home Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

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

How do you prefer to receive information from our office? Email Paper  
(Sara Wasserbauer, MD respects your privacy. We do not sell any of your personal information.)

Employer: \_\_\_\_\_

Any known allergies or allergic reactions? \_\_\_\_\_

\_\_\_\_\_

HOW DID YOU HEAR ABOUT US?

Google / Yodle / Locate-A-Doc / American Health & Beauty / Propecia.com / Newspaper  
ON Magazine / Diablo Magazine / Referral / Other: \_\_\_\_\_

Signature: \_\_\_\_\_

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

**DO YOU HAVE A HISTORY OF: (Please circle "Y" or "N")**

|   |   |   |
|---|---|---|
| Bleeding problems (nose bleeds, gum bleeds, easy bruising, etc.)              | Y | N |
| Poor or abnormal healing (wide scars, raised scars, keloids, slow healing)    | Y | N |
| Liver Problems (Hepatitis)  | Y | N |
| High Blood Pressure   | Y | N |
| Heart Disease (heart attack, arrhythmia, irregular pulse, heart murmur, etc.) | Y | N |
| Lung Disease (asthma, pneumonia, chronic bronchitis)                          | Y | N |
| Hormonal Diseases (Diabetes, Thyroid problems, etc.)                          | Y | N |
| Kidney, Bladder disease (Prostate)  | Y | N |
| Stomach Disease (ulcers, heartburn, etc.)                                     | Y | N |
| Neurological Disease (stroke, seizures, fainting)                             | Y | N |
| Hay Fever, Hives  | Y | N |
| Eczema, Psoriasis   | Y | N |
| Glaucoma  | Y | N |
| Do you have any artificial joints, heart valves, or metal pins                | Y | N |
| Disorders of the Immune System  | Y | N |
| Tattoos   | Y | N |
| Blood Transfusions  | Y | N |
| Emotional Problems (depression, anxiety, panic disorder, etc.)                | Y | N |
| Have you been told you need antibiotics prior to surgery                      | Y | N |
| Rare Disorders (Hereditary Angiodema, Malignant Hyperthermia)                 | Y | N |

Weekly alcohol intake: \_\_\_\_\_ Weekly Cigarette use: \_\_\_\_\_ Drug use: \_\_\_\_\_

Are you allergic to or have a "bad reaction" to any of the following local anesthetics and other medications occasionally used in surgery: (Please circle)

**Novocain – Xylocaine – Skin Tape – Iodine – Valium – Penicillin – Codeine – Prednisone – Substances on skin**

List any other medications to which you are allergic to or have a "bad reaction" to: \_\_\_\_\_

List all prescription and non-prescription medications, drugs, vitamins, or supplements you take either regularly (Including Rogaine, Vitamin E, over-the-counter pain medications like Advil or Motrin, etc.)

Please list any operations (including previous hair transplants) or serious medical conditions not listed above or give details to questions asked:

Personal Care Physician: \_\_\_\_\_ # \_\_\_\_\_

## MALE HAIR LOSS HISTORY

Hair Color: \_\_\_\_\_ Texture: (circle all that apply) Straight / Wavy / Curly / Perm / Kinky

When did you first notice your hair loss: \_\_\_\_\_

Duration: \_\_\_\_\_ Daily Shedding: (average hairs per day) \_\_\_\_\_

How fast are you losing your hair at this time? Slow / Medium / Fast / Very Fast

Have you ever done a "Hair Count"? No / Yes Results: \_\_\_\_\_

Wig/Hairpiece? Yes/ No How long? \_\_\_\_\_

Drugs: Propecia Yes / No How long? \_\_\_\_\_

Rogaine: Yes/ No How long? \_\_\_\_\_

List any other hair loss preventatives: \_\_\_\_\_

Hair Care History: (circle all that apply) Dyes / Bleach / Perms / Straightener / Braiding / \_\_\_\_\_

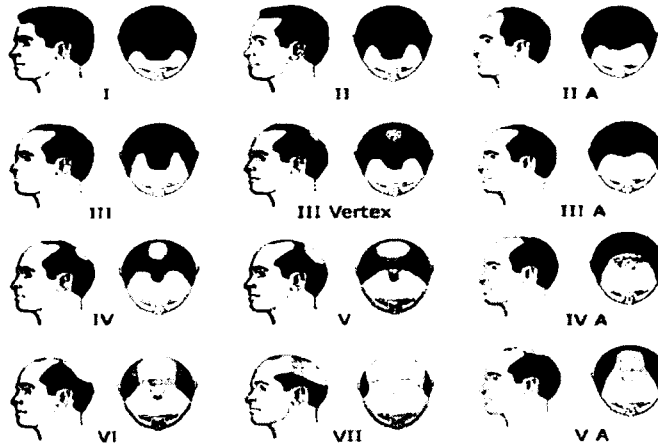
How often: \_\_\_\_\_

On a daily basis do you use? (Circle all that apply) Hair Spray / Mousse / Dryer / Clips / \_\_\_\_\_

Frequency of hair care program: (wash, color, cut, etc.) \_\_\_\_\_

Who has the worst hair loss in your family? Father / Grandfather / Brother / Mother / Grandmother / Sister

**Circle the degree of hair loss which best matches you:**



Patient Name: \_\_\_\_\_

Patient 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 are 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 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 right 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 shall cover all claims or controversies whether in tort, contract, or otherwise, and shall bind all parties whose claims may arise out of or in any way related to treatment or services provided or not provided by the below identified physician, medical group, association, their partners, associates, corporations, partnerships, employees, agents, and/or providers (herein shall be collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient, and to any children, born or unborn, at the time of 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(ren). Filing by Physician of any action in any court by the physician to collect any fees from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claims against 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 by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, the names, addresses and telephone numbers of the patient and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§1-4). The parties shall bear their own costs, fees, and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

**Article 4. Retroactive Effect:** The patient intends this agreement to cover all services rendered and products sold by Physician not only after the date it is signed (including, but not limited to, emergency treatment) but also before it was signed as well.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked, will govern all medical services received by the patient.

**Article 6: Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below I acknowledge that I fully understand and agree to the terms defined in this agreement.

**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.**

SARA WASSERBAUER, MD

Physician

Date

Print Patient's Name

Date

Physician's Signature

Date

Patient's Signature

Date