



WELCOME TO THE MORROW INSTITUTE

OUR MISSION

The Morrow Institute is dedicated to providing the finest medical and surgical treatments to enhance and renew health and beauty. Our unique Specialty Plastic Surgery® approach benefits, you, the patient, by ensuring that each aspect of your care is provided by experienced physician specialists and our highly trained support team.

LEADERSHIP

Our founder and director, David M. Morrow, M.D., a diplomat of American Board of Dermatology and Cosmetic Surgery, internationally recognized as an authority on skin and facial rejuvenation and natural-looking aesthetic surgery.

Dr. Morrow has pioneered several protocols and procedures in his field, including: the Designed Skin Peel, “scar less” surgery and the laser facelift. He has published numerous journal articles and has been asked to present and teach his work to colleagues around the world.

THE INSTITUTE

Amidst breathtaking views of the Santa Rosa Mountains, our fully-accredited state of the art outpatient surgery center provides patients with the ultimate in effectiveness, safety and comfort. It includes two spacious surgical suites and recovery room plus dedicated areas for laser surgery, minor procedures, post operative makeup, clinical photography, private consultations, personalized skin care and a post-operative recovery suite.

TOTAL CARE AND BEYOND

Health and beauty enhancement is more than a superficial undertaking. Many patients tell us that their visit to The Morrow Institute is an important part of their overall quest for personal growth and fulfillment. That is why we are committed to make every aspect of your visit to The Morrow Institute a pleasant positive experience. We make it a point to be responsive to your questions and concerns before, during, and after every procedure. And because surgical and medical intervention is only part of the process toward renewal and rejuvenation, we incorporate a range of natural remedies such as homeopathy, vitamins, and herbs. Our ultimate goal is to help you fulfill the goals *you* have set for yourself.

David M. Morrow, MD, FAAD, FAACS, Medical Director

69-780 Stellar Drive ♦ Rancho Mirage, CA 92270 ♦ phone 760.202.2770 ♦ fax 760.202.4676 ♦ www.morrowinstitute.com

PATIENT INFORMATION

NAME _____ DATE _____

LOCAL DESERT ADDRESS _____

CITY _____ ZIP _____

OTHER OUT OF THE DESERT ADDRESS: _____

PHONE NUMBER WHERE YOU CAN BE REACHED TODAY _____

HOME PHONE(S): _____ FAX: _____

BUSINESS PHONE/FAX _____

EMERGENCY PHONE: _____ CELL PHONE #1: _____

CELL PHONE #2: _____

PRIMARY E-MAIL ADDRESS: _____

SECONDARY E-MAIL ADDRESS: _____

MAILING ADDRESS(ES): LOCAL OR OUT OF THE DESERT FROM WHEN TO WHEN: _____

DATE OF BIRTH _____ **AGE** ____ **MARITAL STATUS** ____ **SEX** _____

SOC. SEC. # _____ **DRIVERS LICENSE #** _____

PATIENT'S OCCUPATION OR FORMER OCCUPATION _____

NAME OF EMPLOYER _____

BUSINESS ADDRESS _____

NAME OF SPOUSE _____

SPOUSE'S OCCUPATION OR FORMER OCCUPATION _____

NAME OF EMPLOYER _____ **BUSINESS PHONE** _____

BUSINESS ADDRESS _____

IF PATIENT IS A MINOR, NAME OF RESPONSIBLE PARENT _____

NAME OF PARENT'S EMPLOYER _____ **BUSINESS PHONE** _____

BUSINESS ADDRESS _____

HOW DID YOU HEAR ABOUT *THE MORROW INSTITUTE*? _____

WHAT IS THE NATURE OF YOUR VISIT? _____

DO YOU HAVE **HEALTH INSURANCE**? [] YES [] NO

PATIENT SIGNATURE (or responsible party)

DATE

GENERAL PATIENT MEDICAL HISTORY

Please complete this form as accurately as possible. The information it contains will enable The Morrow Institute to deliver the highest standard of care to you.

NAME: _____ DATE: _____

1. What is your general state of health? Please check one:

Excellent Good Fair Poor

2. Yes No Do you have any known heart, lung, blood pressure, or diabetic problems?

If yes, please explain. _____

3. Yes No Are you under the care of a physician now? If yes, for what reason?

4. Name and address of personal physician:

5. List ALL medications and tablets you take by mouth, on a DAILY basis (include dosage if possible).

6. Yes No Are you taking aspirin or aspirin containing compounds? If yes, why, what kind, and how many per day? _____

7. Yes No Do you have any allergies to any medications? If yes, specify medication(s) and reaction(s) which occurred, and when: _____

8. Yes No Have you or any relative ever had a bad reaction to a local or general anesthetic? If yes, please explain. _____

9. Yes No Do you smoke cigarettes? If yes, how many cigarettes or packs per day?

10. Yes No Do you drink alcoholic beverages? If yes, please specify type and amount per day or week. _____

11. Yes No Have you ever had a diagnosis of cancer? If yes, please explain. _____

12. Yes No Have you ever had Hepatitis? If yes, what type: A, B, or C _____;
When? _____ How did you acquire it? _____
Do you now have any symptoms? _____
Do you know if you are still a carrier of hepatitis? _____

13. Yes No Have you ever been diagnosed as having AIDS, AIDS Related Complex (ARC),
HIV, pneumocystis pneumonia, etc. If yes, please explain _____

14. Yes No Have you ever been given blood transfusions or blood products? If yes, when
and why? _____

15. Yes No Are you subject to profuse bleeding? If yes, please explain. _____

16. Yes No Have you ever had Bell's Palsy or facial herpes infection? Are you prone to facial
cold sores? If yes, please explain when, and how you treat them. _____

17. FOR FEMALE PATIENTS:

Yes No Are you pregnant? If yes, what month? _____

Yes No Are you a nursing mother? If yes, how much longer are you planning to nurse?

Yes No Are you taking birth control pills? If yes, what type, how long have you taken
them, why do you take them, and how long do you plan to continue? _____

Yes No Are you taking any other hormone preparation? If yes, what kind, dosage, how
do you take it, and why? _____

Is there anything else you would like to tell the doctor at this time? If yes, please do: _____

SIGNATURE OF PATIENT

DATE



PHYSICIAN-PATIENT ARBITRATION AGREEMENT

WHY WE NEED IT

In our litigious environment, it is becoming increasingly difficult to provide quality medical care at a reasonable cost.

The accompanying form binds both you and The Morrow Institute to a standard arbitration procedure in the event a complaint should ever arise. This equitable process avoids the delays, uncertainty and expense of jury trial.

BY SIGNING THIS AGREEMENT YOU ARE NOT GIVING UP YOUR RIGHT AS A PATIENT TO FILE A COMPLAINT OR TO SEEK DAMAGES. Rather, a board of qualified arbitrators will adjudicate any complaints which might arise.

THANK YOU FOR WORKING WITH US TO KEEP DOWN SOARING MEDICAL COSTS AND INSURANCE PREMIUMS.

PHYSICIAN-PATIENT ARBITRATION

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 incompletely 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 right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

This agreement means that any dispute regarding medical malpractice between you and The Morrow Institute will be decided through the means of arbitration. The process of arbitration proceeds as follows:

Within fifteen (15) days from the time the patient becomes aware that there are grounds for a claim, the patient shall notify The Morrow Institute in writing. Within sixty (60) days of such notification, each party shall select an arbitrator and notify the other party in writing of the name and address of that arbitrator. Within thirty (30) days after that, the two arbitrators shall select a third arbitrator. These three arbitrators make up the arbitration board, which will adjudicate any damages and/or compensation.

Both parties agree that the law entitled *California Medical Injury Compensation Reform Act* shall apply to disputes under this Agreement. This includes, but is not limited to: the right to introduce evidence of any amount payable as a benefit to the patient (Civil Code Section 3333.1); the limitation on recovery for non economic losses (CMI Code Section 3333.2); and the right to have a judgment for future damages paid in installments (Code of Civil Procedure, Section 667.7). **By agreeing to this process, the patient does not give up his right to claim damages and request compensation.**

This Agreement would include related claims by any spouse or heirs of the patient for wrongful death, or by the patient or his family or his heirs for emotional distress or punitive damages arising from any claimed intentional or reckless misconduct.

This Agreement may be revoked by written notice delivered to The Morrow Institute within thirty days of the patient signing this Agreement.

Should it be necessary for The Morrow Institute to file a lawsuit to collect any fees which have not been paid by the patient, the filing of such a lawsuit will not affect the obligations of the parties to submit any dispute under this Agreement to arbitration. If any part of this Agreement is held invalid, the remaining portions shall remain valid and not be affected.

NOTICE: BY SIGNING THIS DOCUMENT YOU ARE AGREEING TO HAVE ANY ISSUE REGARDING THE TREATMENT BY THE MORROW INSTITUTE, A MEDICAL GROUP, INC, DR. MORROW, OR HIS ANY ONE OF HIS PHYSICIAN OR NON-PHYSICIAN STAFF DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO JURY OR COURT TRIAL. SEE THE FIRST PARAGRAPH OF THIS CONTRACT.

Patient: Printed Name, Signature, & Date

Morrow Institute Staff Representative: Printed Name, Signature, & Date

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