

Patient Information

Today's Date ___/___/___		MRN# _____
Last Name	First Name	Middle Initial
Marital Status	Age	Date of Birth ___/___/___
Address		
City	State	Zip Code
Home Phone ()	Mobile ()	Work ()
Email Address	Preferred phone for text reminders:	
<i>Would you like to receive appointment reminders and promotions?</i> Text Only Email Only Text and Email		
Occupation:	Employer:	

How did you hear about us?

Medical Health History

Reason for visit:				
Have you had plastic surgery before? yes no				
If yes, type of surgery and when:				
Please list nutritional supplements and medications you are currently taking including hormone replacement therapy and birth control pills:				
Are you presently under a physician's care? yes no If yes, why?				
How is your general health? Excellent Good Fair Poor				
Do you exercise? yes no				
Smoker Date quit smoking: Never smoked				
Other nicotine products used:				
Do you drink alcohol? yes no If yes, type and how often:				
Have you ever used Accutane? yes no If yes when?				
Please check the following conditions you have currently or have experienced in the past:				
Abnormal Bleeding	Frequent Headaches	Seizures		
Anemia	Heart Disease	Stroke		
Asthma or COPD	Hepatitis	Thyroid disorder		
Cancer	High Blood Pressure			
Diabetes	High Cholesterol			
Other condition(s) not listed:				

Allergies/sensitivities:			
Latex	yes	no	
Lidocaine	yes	no	
Prescription drug	yes	no	Name of drug:
Anesthesia	yes	no	

Other allergies/sensitivities not listed:

Previous surgeries:

Date	Type of surgery	Surgeon / Facility

Skin Care History

Have you seen a Dermatologist in the past year? yes no

If yes, list Dermatologist's name and reason for visit:

Please list any skin treatment(s) you are currently having:

Please check if you are presently using or have used in the past any of the following:

Hydrocortisone	Benzoyl Peroxide	Vitamin A	Resorcinol
Hydroquinone	Glycolic Acid (AHA)	Vitamin C	Salicylic Acid (BHA) Sulfur
	Lactic Acid (AHA)		

Please check if you have had any of the following in the last 14 days:

Waxing	Facial Cosmetic Surgery	Permanent Cosmetics	Microdermabrasion
Laser Hair Removal	Botox Injections		Light Treatments
	Collagen Injections		Laser Resurfacing
	Dermal Fillers		Chemical Exfoliation (Peel)

Please check if you are presently using or have used in the past any of the following **prescriptions**:

Tretinoin (Retin A, Retin -A Micro, Renova, Avita)	Tazarotene (Tazorac)	Triluma
	Isotretinoin (Accutane)	Metrogel
	Adepalene (Differin)	Azelaic Acid (Azelex, Finacea)

Any other topical antibiotic:

Please check if you presently have or have had in the past any of the following:

Skin Cancer	Acne	Treatment Reaction
Dermatitis	Rosacea	Hypopigmentation (skin lightening)
Keloid Scarring	Broken Capillaries	Hyperpigmentation (skin darkening)
Herpes Simplex or Cold Sores		

Skin allergies/sensitivities:			
Hydroquinone or skin bleaching agents	yes	no	
Hydrocortisone	yes	no	
Other skin allergies/sensitivities not listed:			
Sun Protection			
Do you use sunscreen?	yes	no	
Do you sunbathe?	yes	no	
Have you tanned in a tanning booth in the last 14 days?		yes	no
Have you had any direct sun exposure in the last 14 days?		yes	no
Have you recently used any self-tanning lotions or treatments?		yes	no
When exposed to the sun do you:			
Always burn, never tan	Always burn, sometimes tan	Sometimes burn, sometimes tan	Always tan
Do you feel your skin is sensitive?	yes	no	
Do you tend to scar easily or form raised scars (keloids)?	yes	no	
<u>Hair Removal/Laser Treatment History</u>			
Have you ever had laser hair removal?	yes	no	
Please check any of the following hair removal methods used in the past six weeks:			
Shaving	Waxing	Electrolysis	Plucking Tweezing Stringing Depilatories
Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma?	yes	no	
If yes, please describe:			
Please list any other necessary information your skin specialist should know before beginning your treatment:			
I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I understand that some skin conditions may require more than one treatment as well as use of home care products as directed to achieve the results desired. Results cannot be guaranteed due to individual skin type(s) and condition(s).			
I agree to inform the provider/staff of ANY changes pertaining to the above questionnaire prior to any future treatments. I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician, nurse or doctor of my current medical or health condition and to update this history now and in the future. A current medical history is essential for the caregiver to execute appropriate treatment procedures. I understand that payment is due at time of all services and products. There are NO REFUNDS on any services.			
Client Signature:		Date:	
_____		_____	

Financial Policies

Minor In-Office Cosmetic Procedures or Aesthetic Treatments:

Minor in-office cosmetic procedures, aesthetic services, and products are self-pay and payment is due, in full, at the time of service. **No refunds** will be issued for completed procedures, services, treatments or products. Cosmetic Center store credit may be issued for aesthetic services not completed. Cosmetic Center Credit may also be issued for skin care products if returned within 15 days of purchase.

Surgical Procedures:

A \$500.00 non-refundable deposit is required to reserve a surgery date and time. This deposit is applied toward the total cost of your surgery. As such, it cannot be applied or used for any other future procedures, products or services. Surgical procedure dates will not be held without the deposit. Remaining balances are due a minimum of two weeks (14 days) before your scheduled surgery date. Surgery procedures not paid in-full two weeks (14 days) prior to the scheduled surgery date will be cancelled or postponed.

Visa, MasterCard, Discover, American Express, cash and personal checks are accepted.

Care Credit is accepted for cosmetic surgery only. **Care Credit** cannot be used for surgery deposit. *Medkey and Charity Care are not accepted for cosmetic surgeries, procedures, aesthetic services or products.*

Insurance and Cosmetic Surgeries, Procedures, Aesthetic services and products:

Cosmetic surgeries, procedures, aesthetic services or products are not covered under health insurance. The Carilion Clinic Cosmetic Center does not accept insurance payment for any surgeries, procedures, services and products rendered at the Center and, will not assist patients in attempting to obtain insurance payment coverage. Attempts at obtaining insurance payments for the above listed surgeries, procedures, services and products may be considered fraud.

COMPLICATIONS AND UNSATISFACTORY RESULTS:

Postoperative complications are rare. However should postoperative complications arise necessitating care at an emergency department, a hospital admission, additional surgery, anesthesia, laboratory tests, etc., patients are responsible for any and all charges incurred. Depending on an individual's plan and coverage, insurance may not cover any or all charges.

Although good results are expected, there is no guarantee or warranty, expressed or implied, of the results that may be obtained for any service, procedure or product performed or sold at the Center. Additional services, procedures or products may be required to improve results of, or to correct or improve conditions caused by complications, risks or side effects of, services, procedures or products. Financial responsibility of additional services, procedures or products will rest with the patient.

I have read thoroughly, understand and agree to the above policies and conditions.

Client Signature:

Date:



Office Policies

Cancellations Non-Surgical Procedures and Appointments:

We understand that a situation may arise that could force you to postpone your consultation and other non-surgical appointments. Please understand that such changes affect not only your care provider, but other patients as well. We request that you please notify our office at least 24 hours in advance to cancel or reschedule an appointment.

Photographs:

I understand that photographs are an important component in the process of plastic surgery. They are taken to allow both the patient and physician to identify asymmetries, abnormalities and areas of concern. They also allow the physician to use computer imaging to better assist the patient in appreciating the goals of surgery and compare preoperative photographs with postoperative results.

****Photographs are considered medical documentation and are protected as such****

Therefore, I consent to having my picture taken for medical documentation

Prescriptions and Refills:

Many medications can interact and need to be monitored. For your safety, prescriptions will only be written between the hours of 8:00A-4:30P Monday through Friday, when your chart can be reviewed. Please have your pharmacist call our office for your medical refills. Please allow Carilion Clinic Cosmetic Center 48 hrs to process prescription refills. Our physician on call is not available to provide prescriptions after hours.

In Case of Emergency:

For emergencies during regular hours office hours Monday - Friday 8:30A-4:30P - 540-853-0510

For emergencies after office hours/weekends/holidays -540-981-7000 and ask for the Carilion Plastic surgeon on call

A Carilion Clinic Plastic Surgeon is available for emergencies 7 days a week, 24 hours per day

Release of Medical Records:

You may request a copy of your medical records at any time by completing a medical record release form Carilion Clinic Cosmetic Center may charge a fee for the records. To protect patient confidentiality, we do not release medical information by telephone or to anyone other than the patient, except allowed by law.

Non-Participating Insurance Acknowledgement:

Carilion Clinic Cosmetic Center does not participate with any health insurance provider. There will be no exceptions to this policy. See Financial Policy for complete details.

I have read thoroughly, understand and agree to the above policies and conditions.

Client Signature:

Date: