BROWN PLASTIC SURGERY

S

Patient Information Form

Today's Date: ____________

First Name: ________________________________ M.I. ______ Last Name: _____________________________

Address: ____ City: ______________ State: _____ Zip: _______

Date of Birth: __________________ Age: ___________ Gender: Male Female Other

Home Tel: ____________________ Work Tel: ___________________Mobile Tel: __________________________

E-mail: ____

Preferred Contact Method? (circle) Home Phone Work Phone Cell Phone

Ok to leave a message on Home Phone? Yes / No Ok to leave a message on Cell Phone? Yes / No

Ok to email you specials/flyers? Yes / No Ok to Text? Yes / No

Employer Name: ______________________________ Address: ____

Occupation: __________________________________ Work Phone: _____________________________________

Reason for Visit: ____

REFERRAL SOURCE: How did you hear about Skyler?

Instagram Google RealSelf Yelp Facebook Other: _______________________________

Keywords Used: ______________________________ Patient Referral: _______________________________

EMERGENCY CONTACT INFORMATION

Name: ______________________________Phone: ____________________Relationship: ____________________

Scottsdale: 11000 N Scottsdale Road, Ste 100, Scottsdale, AZ 85254
Sun City: 13640 N 99th Ave, Ste 400, Sun City, AZ 85351
Phone: 480.947.2455 Fax: 480.947.2456

Patient Health History

Patient Name: ______________________ **Height:** __________ **Weight:** __________

Allergies/Medications

Are you allergic to any medications or local anesthetics? Yes / No

If yes, please list: ____

Do you have any food or drink allergies? Yes / No

If yes, please list: ____

Are you currently taking any medications or supplements? Yes / No

If yes, please list ALL medications that you are currently taking or have taken within the last 7 days. This includes prescriptions, over-the-counter medications, vitamins, and supplements (internal or topical).

____

Do you pre-medicate for any medical procedures (such as: prescribed antibiotics)? Yes / No

Are you currently taking, or have you completed Accutane therapy? Yes / No

If yes, when? ____

Social History

Do you drink alcohol? Yes / No If yes, how often: __________

Do you smoke or are you a previous smoker? Yes / No If yes, how often or when did you stop: __________

For Women Only

Are you pregnant? Yes / No

Are you trying to become pregnant? Yes / No

Are you nursing? Yes / No

Health History Continued

Have you had any dental work, flu shot, vaccines, UTIs, or other active infections within the last four weeks? Yes / No

If yes, please list and include dates: ______________________________

Will you be flying in the next 48 hours? Yes / No

Is there a history of raised scarring (keloid) after injury or surgery? Yes / No

Do you bleed easily? Yes / No

Do you have a history of herpes simplex virus (cold sores)? Yes / No

☐ Denies Past Medical History	☐ High Blood Pressure
☐ Emphysema	☐ Neuromuscular Disorder, type: __________
☐ Asthma	☐ Kidney Stones
☐ Breast Cancer	☐ Skin Cancer
☐ Cancer (Other)	☐ Skin Disease
☐ Heart Attack	☐ Stroke
☐ Diabetes	☐ Thyroid Disease
☐ Facial Implant	☐ Tuberculosis
☐ Seizure Disorder	☐ Stomach Ulcers
☐ Heart Disease	☐ Bleeding Disorder
☐ Heart Murmur	☐ Auto Immune Disorder, type: __________
☐ Hepatitis	☐ Arthritis, type: __________
☐ HIV	☐ Other __________

List any surgical procedures you have had, and date of:

____

____

Areas of Concern

Please check all that apply or that you may have questions about.

Frown lines ☐
Laughter lines (crow's feet) ☐
Hollowness under eyes ☐
Glabellar lines (number 11's) ☐
Eyebrow lift ☐
Nasalis (bunny lines) ☐
Loss of volume in cheeks ☐
Thins lips ☐
Gummy smile ☐
Downturned mouth ☐
Ear lobe correction ☐
Marionette lines ☐
Jawline ☐
TMJ/ Facial Slimming ☐
Mentalis (pebble/cellulite/pitted chin) ☐
Platysmal bonds ☐

Uneven skin tone ☐
Dry, dull skin ☐
Age spots ☐
Acne scars ☐
Hair loss ☐
Skin Care Regimen ☐

Other areas of concern or anything else you would like Skyler to address:

____

____

Products you currently use:

____

____

Patient Photo Consent Form

I, ______________________________, ____________________
First Name, Last Name Date of Birth

agree that the images and / or videos may be used for:

(Please circle Yes or No below to show consent type)

Medical documentation purposes (<u>mandatory if receiving treatment</u>)	Yes / No
In-office before and after book	Yes / No
Website and social media	Yes / No

I further acknowledge that there were no promises of compensation for such use of medical photos and / or videos taken by Brown Plastic Surgery. This consent may be revoked at any time with written request from patient.

By signing below, I confirm that I understand this consent form.

______________________________________ ____________________
Signature of Patient / Parent or Guardian Date

Commitment Form

Our Commitment

At Brown Plastic Surgery we are committed to excellence. We feel that you deserve nothing less when it comes to your health. We use the best materials and techniques available in order to provide you with the quality you have come to expect from us.

We believe that our relationship with you, as with all relationships, needs open and clear communication. We will try our best to communicate all your needs and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning our services.

We understand how valuable your time is, so we make every effort to remain on time. We do not double book our appointments. We feel that you deserve our complete and focused attention so that we may provide the best care possible. Your reserved time is exclusively yours.

Your Commitment

We want you to be comfortable with our team. If you ever have any questions about your treatment, financial information or any other concerns, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.

Payment for your treatment is expected at the time of your services. For your convenience we do accept many forms of payment including, cash, check, Visa, Mastercard and American Express.

Your scheduled appointment is reserved exclusively for you. We have a 48-hour cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change your appointment time if a 48-hour notice is given. If sufficient notice is not given, your account will automatically be charged a $50.00 missed appointment fee. We ask that you make every effort to keep your reserved time.

Patient/Guardian: ______________________________
Team Member/ Date: ___________________________

Acknowledgment of Receipt of Privacy Notice

I attest the medical information provided is current and accurate to the best of my knowledge. I understand the signed copy of the privacy policy will be placed in my chart indicating that I have read, understood and agree to this policy. A copy of this may be obtained at any time upon your request.

I acknowledge that I have received a copy of the office's **Notice of Privacy Policies.**

Signature of Patient / Parent or Guardian Date

Printed Name (If Signed on Behalf of the Patient) Relationship Date

Please check here if you would like a copy of our Notice of Privacy Policies. ☐

Statement of Financial Responsibility

I understand that payment for services, whether cosmetic or not, is solely the responsibility of the patient or their guarantor.

Signature of Patient / Parent or Guardian Date

Printed Name (If Signed on Behalf of the Patient) Relationship Date