

PATIENT DEMOGRAPHIC SHEET

Name: _____ Date: _____

Occupation: _____

Gender: _____ Marital Status: _____

Date of Birth: _____ SSN: _____

HOME:

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

E-Mail Address _____

Never miss a thing! Yes! I want to receive monthly newsletters with special promotions & perks!

How would you prefer to be contacted? _____

WORK / SCHOOL:

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please list family members or other persons, whom we may inform about your treatment, scheduling, and billing information.

Name	Relationship	Date of Birth	Phone#	Emergency Contact?
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

How did you hear about The Cosmetic and Skin Surgery Center?

May we send a thank you note to the person who referred you (if applicable)? Yes No

Prepaid packages are final, nonrefundable and nontransferable; and must be used within 12 month from date of prepayment.

Patient Signature: _____ Date: _____

THE COSMETIC AND SKIN SURGERY CENTER
SURGERY INFORMATION SHEET

Name: _____ Date: _____

What area(s) are you interested in having improved? Please describe past treatments to this area.

What do you use on your skin in the morning? _____

What do you use on your skin in the evening? _____

Have you ever had or used the following?

Permanent makeup Yes No

Injected fillers (e.g. Juvéderm, Restylane, collagen) Yes No

Neurotoxins (e.g. Botox, Dysport, Xeomin) Yes No

Accutane Yes No

MEDICATION & ALLERGIES

(Please use the Medication Reconciliation Record)

Are you taking aspirin or medication containing aspirin? Yes No

Are you taking other NSAIDs (e.g. Advil, Aleve, etc.) Yes No

Have you taken any steroid preparations in the past year? Yes No

Do you take prophylactic antibiotics prior to procedures? Yes No

If yes, please state reason. _____

MEDICAL EVALUATION

How is your general health? _____

Are you presently being treated for any medical conditions? _____

When was your last physical examination? _____

Do you have any of the following?

Visual loss (one or both eyes) Yes No

“Dry” eyes Yes No

Itching or irritation of eyes Yes No

Blurred or double vision Yes No

Crossed or lazy eyes Yes No

Cornea problems Yes No

Thyroid eye disease Yes No

Wear glasses or contacts Yes No

Previous eye or eyelid surgery (if yes what type) Yes No

Difficulty breathing through nose Yes No

Previous injury to nose Yes No

Nasal allergies Yes No

Nose bleeds Yes No

Sinus conditions Yes No

Previous nasal or sinus surgery (if yes what type) Yes No

Previous face or neck surgery (if yes what type) Yes No

Radiation to the face or neck Yes No

Facial paralysis or weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Facial implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coronary or heart attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Palpitations, irregular heartbeat or pacemaker/defibrillator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizure Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you received psychiatric treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, were you hospitalized?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has there been any recent crisis in your life?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been treated for drug or alcohol dependency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver disorders including hepatitis or cirrhosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney or bladder disorders or chronic infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spinal or back disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Previous blood clots or thrombophlebitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any bleeding disorders in self or family	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel that for any reason you may be at risk for AIDS?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Autoimmune diseases (e.g. lupus, rheumatoid arthritis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any unusual scarring or keloid formation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If applicable, are you pregnant or trying to get pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cold Sores	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you smoke? (If yes please list packs per day and years)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you use an electronic cigarette or vape?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use nicotine in any form? (e.g. patches, gum, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you drink more than two drinks per day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a communicable disease in the past six months? <input type="checkbox"/> Y <input type="checkbox"/> N		

If yes, please explain: _____

The information above is true and accurate to the best of my knowledge. _____
 Patient Signature

Primary Care Physician: _____ Phone Number: _____

Please list below any questions you would like to have specifically answered during your consultation.

Patient Financial Responsibility & Cancellation Policy Form

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have outlined the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance, full payment is due at the time of service.

YOUR INSURANCE

We will be happy to bill your insurance carrier for you; however, any copayments, deductibles, and coinsurance are due at the time of service. In some circumstances, we may request prepayment for services. If your health plan determines that a service is “not covered,” you will be responsible for the full charge. In that case, we will bill you, and payment is due upon receipt of the statement.

MINOR PATIENTS

For all services rendered to minor patients, the accompanying adult is responsible for payment.

PAYMENT METHODS

We accept cash, checks, and major credit cards. A \$25.00 returned check fee will be applied for insufficient funds.

COMPLETION OF FORMS

We will be happy to complete insurance/disability forms for our patients; however, our fee for this service is \$10.00 per form.

CANCELLATION AND NO-SHOW POLICY

To ensure access for all patients and respect our providers’ time, we require at least 24 hours’ advance notice for cancellations. The following fees will be charged directly to patients for no-shows, late arrivals, missed appointments, or same-day cancellations:

- General Dermatology Appointments: \$50.00
- Cosmetic Appointments and ED&C’s: \$100.00
- Mohs Surgery and Excisions: \$200.00

These fees are not billable to insurance and are the patient’s responsibility.

COSMETIC CONSULTATION FEE

Cosmetic consultation fees are nonrefundable and must be applied to in-office treatments within six (6) months of the consultation. *Fees may not be applied toward product purchases.*

DELINQUENT ACCOUNTS

We reserve the right to add reasonable collection fees to any account more than 60 days past due.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient or Responsible Party if a Minor

Date

Please Print the Name of the Patient

Date

