

PATIENT INFORMATION:

Name: _____ Home #: (____) _____ - _____
 Address: _____ Cell #: (____) _____ - _____
 City: _____ State: _____ Zip: _____ E-mail: _____ @ _____
 DOB: ____/____/____ Age: _____ Sex: M / F
 Married? Y / N Spouse Name: _____
 SSN: ____/____/____ Driver's License #: _____
 Occupation: _____ Work #: (____) _____ - _____
 Employer: _____ City: _____

NEXT OF KIN/FRIEND NOT LIVING WITH YOU:

Name: _____ Relationship: _____ Phone #: (____) _____ - _____

IF PATIENT IS A MINOR, PLEASE COMPLETE:

Name of Parent/Guardian: _____ Phone #: (____) _____ - _____
 Employer: _____ Work #: (____) _____ - _____

DID A PHYSICIAN REFER YOU?

Physician Name: _____ Tel #: (____) _____ - _____
 Address: _____ City: _____ State: _____

IF NOT, HOW DID YOU HEAR ABOUT US?

- Friend/Family Saw our sign Insurance Book Google Frisco Style
 AT&T Collin County Yellow Pages Verizon Collin County Yellow Pages
 Verizon Denton County Yellow Pages Frisco Fastfind Telephone Book Our Website
 Other: _____

INSURANCE/PAYMENT INFORMATION (if not self):

Insured Person's Name: _____ Relationship: _____
 DOB: ____/____/____

NOTICE REGARDING PAYMENTS/INSURANCE CLAIMS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of visit. If you cannot provide the information, we will be unable to file your insurance and payment in full will be required on the day the service is provided.

The exact payment amount cannot be determined with complete accuracy until the claim is submitted to your insurance company. Your payment will be based on your individual health plan, deductible and/or coinsurance. Procedures and evaluations, which are excluded from coverage including cosmetic procedures (benign mole removal, skin tag removal, cosmetic procedures, etc) and cosmetic evaluations, based on your plan's determination of medical necessity, will also be your responsibility. Your office co-pay is due at the time of the visit and, in most cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance usually apply. For all other patients, payment in full is required at the time of service.

Standard office policy requires that you must present your drivers' license (or ID), insurance card (if applicable) and a credit/debit card for verification and for our records.

I have read the above information and understand that I am responsible for payment of services I receive.

Patient/Guardian Signature: _____ Date: _____

Cosmetic Consultation

Name: _____

- Cataracts Cancer Osteoarthritis Osteoporosis Glaucoma Asthma
- Diabetes Hay Fever Asthma HIV/AIDS Kidney Dz Thyroid Dz
- Heart Dz Liver Dz ↑Blood Pressure Nail Disorder Epilepsy Acid Reflux
- ↑cholesterol Pacemaker/defibrillator

Currently Pregnant/Due Date: ____/____/____ Currently Breastfeeding

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

Circle one: Smoke: Yes / No Drink Alcohol: Yes / No If yes, how many? _____
Have you had any recent tanning bed or sun exposure (past 4 weeks)? Yes / No

Which best describes your skin type (check one box only)?

- 1. Always burns, never tans
- 2. Burns easily, tans poorly
- 3. Tans after initial burn
- 4. Burns minimally, tans easily
- 5. Rarely burns, tans darkly easily; Moderately pigmented (Hispanic, Asian, Mediterranean, very light skin AA)
- 6. Never burns, always tans darkly; Darkly Pigmented (African-American)

What treatments are you interested in (check all that apply)?

- Microdermabrasion Chemical Peels Laser Hair Foto-facials Skin Resurfacing Waxing

What are your cosmetic concerns (check all that apply)?

- Brown spots Skin discoloration Redness Facial Veins Leg Veins Scarring
- Breakouts Skin Texture Fine lines/wrinkles Skincare regimen

Please check any of the following you are currently using?

- Retin-A/Tretinoin Glycolic Acid/Alpha-hydroxy acid Accutane (within last year) Vitamin C
- Zovarix/Famvir/Acyclovir/Valtrex Hormone replacement Birth Control Pills Antibiotics
- Skin lightening products Acne medications (if so, which ones _____)

Medication/Product Allergies

Medication:

Reaction:

Medication:

Reaction:

Please list your current skin care regimen:

AM

PM