PATIENT INFORMATION

NAME ______________________ BIRTHDATE ____________

ADDRESS ______________________

CITY ____________ STATE ____________ ZIP CODE ____________

HOME PHONE ____________ BUSINESS PHONE ____________

MOBILE PHONE ____________ EMAIL ____________

EMERGENCY CONTACT ____________ EMERGENCY # ____________

Is there a # a message can be left regarding treatment? ____________

Would you like to receive emails regarding discounts/specials? Yes / No

How did you hear about us?

- ☐ referral from a friend :____________
- ☐ A referral from a Doctor/employee: ____________
- ☐ The Internet: ____________
- ☐ One of our brochures: ____________
- ☐ Facebook: ____________

Have you ever seen one of our Plastic Surgeons at DPSI? Yes / No
Which Dallas Plastic Surgery Physician have you seen? ____________

Do you use Retin-A? ____________ If yes how often? ____________

Do you use any products that contain alpha-hydroxy acids? ____________

Allergies to Medications? ____________

RESPONSIBLE PARTY: (IF A MINOR)

Name ____________ Relationship to Patient ____________

Address ____________

City/State/Zip ____________ Phone ____________

We Accept MasterCard, Amex, Visa, Discover, Check, Cash - Due at Service

CANCELLATION POLICY:
Due to scheduling considerations,
we request a 24 hour notice for cancellations.

EpiCentre Dallas I 9101 N. Central Expressway, Suite 500 I Dallas, TX 75231 I 214-887-1577
EpiCentre Plano I 5425 W. Spring Creek, Suite 105 I Plano, TX 75024 I 469-229-0598

PATIENT EVALUATION/CHECKLIST

Name ____ Date ________________

Birthdate __________ Age _____ Male / Female HT _____ WT _____ Marital Status _______

Allergies to Medications? ____

Cosmetics ____

History of Herpes/Fever Blister/Shingles ______________ Date of Last Outbreak __________
With + hx. of herpes – Start pt. on Valtrex 500mg. BID 2 days pre & 3 days post tx.
Rx Written/Called in to ____________________ Date ________ Pharmacy # __________

Skin Type:			
	I	White	always burn, never tan
	II	White	often burn, difficult tan
	III	White	sometimes burn, often tan
	IV	Olive/Lt. Brown	rarely burn, easily tan
	V	Brown	rarely burn, always tan
	VI	Black	never burn, always tan

Circle All Nationalities Associated with your Genetic Makeup:
White Asian Hispanic Mediterranean Middle Eastern Afro American
Indian Irish English German Greek Italian Spanish/Portuguese

Skin Type: Oily vs. Dry Sensitive vs. Resistant Pigmented vs. Non-pigmented
Rosacea Wrinkled vs. Tight Acne Prone

What cosmetic goals do you wish to attain ____

What areas are you interested in treating? ____

Sun Exposure?	☐ Frequent	☐ Moderate	☐ Minimal	☐ Tanning Beds
Do you use a sunscreen?		☐ Daily	☐ Occasionally	☐ Only for outdoor use
	☐ Face	☐ Body	☐ SPF _____	Brand __________

Have you ever had permanent makeup tattooing? Yes / No / N/A If so, when? ________

Circle If Applies To You:

Are you lactating/ pregnant or attempting to become pregnant?	Yes / No
Have you ever had a pregnancy mask/melasma?	Yes / No
Are you on Birth Control Pills / Patch / HRT?	Yes / No
Perimenopausal~Menopausal~Postmenopausal~Hysterectomy	Yes / No Year__________

Do you smoke or have you ever? Yes / No Years _____ When did you quit? ______________

Do you have a metal stent or implant in your face? Yes / No

Have you had the Following Cosmetic Procedures on the Brow or Lower Face Areas:

Facial Tightening Treatment within the last year?	Yes / No	Date_______________
Injectable Filler?	Yes / No	Date_______________
Botox/Dysport?	Yes / No	Date_______________
Ablative Skin Resurfacing?	Yes / No	Date_______________
Dermabrasion or Deep Chemical Peels?	Yes / No	Date_______________
Facelift or Blepharoplasty	Yes / No	Date_______________

Medications currently using?

☐ Retin-A ☐ Glycolic/Lactic Acids ☐ Photosensitivity Medications
☐ Topical Cortisone/Antibiotics ☐ Skin bleaching agents
☐ Aspirin-NSAIDS Last dose ____
☐ Anticoagulants/Antiplatelet Last dose ____
☐ Accutane (within last 6 months?) If so, when? ____

List All Medication Currently Taking Including Over the Counter Vitamins/Supplements.
Include Dose/Frequency/When Started and Last Dose taken: ____

____
____
____

Do you have a history of the following: **may alter wound healing*

☐ Vitiligo
☐ High blood pressure
☐ Asthma
☐ Hives
☐ Hepatitis
☐ Heart or Lung disease
☐ *Diabetes
☐ Migraine headaches
☐ HIV /AIDS
☐ Hives
☐ Alopecia/Hair Loss
☐ *Anorexia
☐ Cancer
☐ Disease of Nerve/ Muscles
☐ Pacemaker

☐ *Bleeding disorder
☐ *Bruise easily
☐ Fainting/ Dizzy Spells
☐ Epilepsy/Seizures
☐ Chicken Pox/Shingles
☐ Arthritis ____Gold Therapy for Arthritis?
☐ Dark spots after pregnancy, skin injury, or surgery
☐ Do your scars turn brown before they fade
☐ Do your scars turn permanently white
☐ Eczema/Skin Diseases/Keloid Scaring
☐ *Hypothyroidism/Hashimotos
☐ Hyperthyroidism
☐ Fibromyalgia
☐ *Autoimmune Disorder
(Lupus, Rheumatoid Arthritis)

Any additional information or medical conditions that you would consider pertinent? Yes / No
Please specify ____

Dermatologist: ___________________________ Last Visit/Reason ____

Due to the marked increase in skin cancers over the past decade, it is the recommendation that every patient obtain a yearly skin check with a board certified dermatologist. We will be happy to refer you. This office will not treat suspicious lesions without a signed medical release from your dermatologist. ______ Patient Initials

Patient Signature ____ Date _____________________

Annual Review: Date: _____ Initial ______

Annual Review: Date ______ Initial ______

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge and agree that I have been provided a copy of EpiCentre, PLLC's Notice of Privacy Practices that describes how my protected health information must be protected and my rights to access and control such information. I acknowledge and agree that I have reviewed the Notice of Privacy Practices in its entirety and been given the opportunity to ask any questions regarding the use or disclosure of my protected health information and my associated rights. I acknowledge and agree that I have had all my questions answered to my satisfaction.

PATIENT SIGNATURE ____ DATE ______________
(OR PERSONAL REPRESENTATIVE)

PRINTED NAME ____

PERSONAL REPRESENTATIVE'S AUTHORITY ____________________________
(IF APPLICABLE)

FOR OFFICE USE ONLY
EPICENTRE, PLLC WILL MAKE A GOOD FAITH EFFORT TO OBTAIN A WRITTEN ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES PROVIDED TO EACH PATIENT. IF A PATIENT IS UNWILLING OR UNABLE TO SIGN THIS ACKNOWLEDGMENT, THE GOOD FAITH EFFORTS TO OBTAIN SUCH ACKNOWLEDGMENT AND REASON WHY THE ACKNOWLEDGMENT WAS NOT OBTAINED MUST BE DOCUMENTED.
REASON:

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CANCELLATION POLICY

Your appointments are very important to the team members of EpiCentre and these times are reserved especially for you. We understand that sometimes schedule adjustments are necessary; therefore, we respectfully request at least 24 hour notice for cancellations.

STRICT AND ENFORCED 24 HOUR CANCELLATION POLICY!

Please understand that when you forget or cancel your appointment without giving enough notice, we miss the opportunity to fill that appointment time and patients on our waiting list miss the opportunity to receive services. Our appointments are confirmed 48 hours in advance because we know how easy it is to forget an appointment you booked months ago. Since the services are reserved for you personally, a Cancellation Fee will apply.

1. Less than 24 hour notice will result in a charge equal to 50% of the reserved service amount.
2. "NO SHOWS" will be charged 100% of the reserved service amount. If you prepaid for a service or package, that service will be taken out of your package as if it were used at that particular time.
3. Appointments made within the 24 hour period and need to cancel, the patient must cancel within 4 hours of appointment time or will result in a charge equal to 50% of the reserved service amount.
4. Please understand late arrivals will not receive an extension of scheduled services in order to prevent inconvenience to the next patient scheduled and the same treatment price will apply.
5. Any service requiring a 2 hour or more appointment time, will require a 50% deposit to hold that particular appointment.

Our Cancellation Policy allows us the time to inform our standby patients of any availability, as well as keeping our EpiCentre team member's schedules full, thus better serving everyone. EpiCentre policies are presented and provided in the best quality and tradition of excellent service for our established and future patients. Thank you for viewing and supporting our policies criteria.

Print Name ____

Signature _____________________________________Date ______________

RETURN POLICY

Absolutely NO refunds on services, packages or products.

All pre-paid services and packages must be used within one year from the date of purchase.

Product returns or exchanges must be within 30 days from date of purchase and must be unopened with your receipt. A credit will be issued to be used within EpiCentre.

NO REFUNDS!

Print Name ____

Signature _______________________________________Date _______________

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