



PATIENT INFORMATION

DATE: _____

NAME _____ AGE _____ 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: _____
- Internet/Website: _____
- One of our brochures: _____
- Social Media: _____

Have you ever seen one of our Plastic Surgeons at DPSI? Yes / No

Which Dallas Plastic Surgery Physician have you seen? _____

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.



PATIENT EVALUATION/CHECKLIST

Male / Female Height _____ Weight _____

Allergies to Medications? _____

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:

Caucasian	Asian	Hispanic	Mediterranean	Middle Eastern	African American
Native American	Irish	German	Greek	Italian	Spanish

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?	<input type="checkbox"/> Frequent	<input type="checkbox"/> Moderate	<input type="checkbox"/> Minimal	<input type="checkbox"/> Tanning Beds
Do you use a sunscreen?	<input type="checkbox"/> Face	<input type="checkbox"/> Body	<input type="checkbox"/> Daily	<input type="checkbox"/> Occasionally
			<input type="checkbox"/> SPF _____	<input type="checkbox"/> Only for outdoor use
				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?

<input type="checkbox"/> Retin-A	<input type="checkbox"/> Glycolic/Lactic Acids	<input type="checkbox"/> Photosensitivity Medications
<input type="checkbox"/> Topical Cortisone/Antibiotics	<input type="checkbox"/> Skin bleaching agents	
<input type="checkbox"/> Aspirin-NSAIDS	Last dose _____	
<input type="checkbox"/> Anticoagulants/Antiplatelet	Last dose _____	
<input type="checkbox"/> 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*

<input type="checkbox"/> Alopecia/Hair Loss	<input type="checkbox"/> Eczema/Skin Diseases/Keloid Scarring
<input type="checkbox"/> *Anorexia	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Arthritis ____ Gold Therapy for Arthritis	<input type="checkbox"/> Fainting/ Dizzy Spells
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> *Autoimmune Disorder (Lupus, Rheumatoid Arthritis)	<input type="checkbox"/> Heart or Lung disease
<input type="checkbox"/> *Bleeding disorder	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> *Bruise easily	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV /AIDS
<input type="checkbox"/> Chicken Pox/Shingles	<input type="checkbox"/> Hives
<input type="checkbox"/> Dark spots after pregnancy, skin injury, or surgery	<input type="checkbox"/> *Hypothyroidism/Hashimotos
<input type="checkbox"/> *Diabetes	<input type="checkbox"/> Migraine headaches
<input type="checkbox"/> Disease of Nerve/ Muscles	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Do your scars turn brown before they fade	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Do your scars turn permanently white	<input type="checkbox"/> Vitiligo

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 _____



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:



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 _____