EpiCentre
Skin Care & Laser Center
SM

PATIENT INFORMATION

DATE: _____

NAME _____ AGE_____ BIRTH DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE_____

HOME PHONE _____ BUSINESS PHONE_____

MOBILE PHONE _____ EMAIL_____

PHARMACY _____ PHARMACY # _____

EMERGENCY CONTACT _____ EMERGENCY # _____

Is there a number 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/Social Media: _____
- ☐ Other: _____

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.

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PATIENT EVALUATION/CHECKLIST

Male / Female Height _____ Weight _____

Circle All Nationalities Associated with your Genetic Makeup:

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

What cosmetic goals do you wish to attain? _____

What areas are you interested in treating? _____

Sun exposure: Hours per/day/week/month _____
Do you use a sunscreen? ☐ Yes ☐ No SPF_____

Have you ever had microblading/permanent makeup tattooing? ☐ Yes ☐ No
What area(s) _____

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

Do you get cold sores? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

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 _____

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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:

HISTORY AND PHYSICAL

Patient Name _____ Date _____

DOB_____ Gender _____ Ethnicity_____ Fitz _____ Glogau Stage_____

CHIEF CONCERN

- ☐ Fine lines/wrinkles, wrinkles with movement
- ☐ Deep folds around nose/mouth
- ☐ Thinning lips
- ☐ Sagging skin/tissue (face/body)
- ☐ Acne/Rosacea
- ☐ Skin dullness
- ☐ Volume loss
- ☐ Enlarged pores/acne scars/scars
- ☐ Skin discolorations (Hypo/hyperpigment, redness)
- ☐ Rough skin texture/dryness
- ☐ Unwanted body fat
- ☐ Excessive/unwanted perspiration
- ☐ Cellulite/dimpling
- ☐ Other _____

HPI

_____

_____

_____

ROS

- ☐ Excessive swelling/Angioedema post tx
- ☐ Headache post NM
- ☐ Hypopigmentation
- ☐ Lidocaine Sensitivity
- ☐ Paradoxical adipose hyperplagia
- ☐ Post inflammatory hyperpigmentation
- ☐ Prolonged bruising/bleeding
- ☐ Prolonged healing
- ☐ Prolonged pain
- ☐ Stress Incontinence
- ☐ Vaginal dryness
- ☐ Vascular occlusions
- ☐ Other _____

PMH

- ☐ Cold sores/HSV
- ☐ Acne/rosacea
- ☐ Alopecia/hair loss
- ☐ Atopic dermatitis
- ☐ Autoimmune disorders:_____
- ☐ Bleeding disorders
- ☐ Cancer: Type:_____ Date:_____ Chemo/Radiation
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Eczema/psoriasis
- ☐ GI disorders
- ☐ H/O chicken pox/shingles
- ☐ Heart disease
- ☐ Hernias
- ☐ Hepatitis C
- ☐ HIV/MRSA/Tb//G+
- ☐ Hypertension
- ☐ Hypo/hyperthyroidism
- ☐ Liver/kidney disease
- ☐ Lung disease (COPD/Asthma)
- ☐ Melasma
- ☐ Metal implants
- ☐ Migraines
- ☐ NM/motor neuron disorders/stroke Bells Palsey/Guillain Barre
- ☐ Scars (keloid/surgical/traumatic)
- ☐ Seizure/Vertigo
- ☐ Skin cancer: Type_____ Location:_____ Date:_____
- ☐ Skin moles/lesions
- ☐ Sleep apnea/CPAP
- ☐ Other:_____

PSH

- ☐ Abdominoplasty
- ☐ Bleph (upper/lower)
- ☐ Breast aug/reduction
- ☐ CO2/erbium laser
- ☐ Dental procedures:_____
- ☐ Face lift (upper/lower/neck)
- ☐ Facial implants: Location_____
- ☐ Hernia repair
- ☐ Joint replacement
- ☐ Liposuction
- ☐ Rhinoplasty
- ☐ Other:_____

PAST AESTHETIC PROCEDURES

- ☐ Peels/laser tx
- ☐ Skin tightening:_____
- ☐ Other:_____
- ☐ Fat reduction:_____
- ☐ Dermal filler:_____
- ☐ Neuromodulator:_____
- ☐ Kybella:_____
- ☐ PDO threads:_____
- ☐ Sculptra:_____

MEDICATIONS/SUPPLEMENTS

Name	Reason for Taking	Frequency/Dose

ALLERGIES

☐ Medication _____ Type of Reaction _____

☐ Food _____ ☐ Lidocaine _____ ☐ Seasonal_____

SOCIAL HISTORY

Marital Status _____ Use of Retin A/Retinol _____ Sun exposure _____hours per day/wk/mo
Skincare/SPF _____ Tobacco: Cigs/day ___ years___Quit Date _____ Alcohol Intake _____drinks per day/wk/mo
Occupation_____ Illicit Drug Use _____ Exercise type _____hrs/week_____

GYN HISTORY

LMP _____ BCP/HRT_____ Onset of Menopause_____ Lactating _____

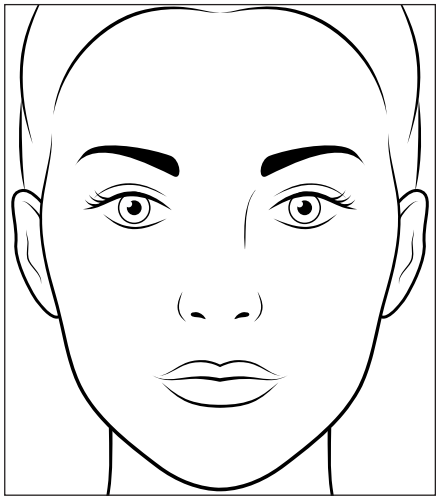
PE

General: WDWN _____ Age_____ ☐ Appears stated age ☐ Younger than stated age ☐ Older than stated age

Skin: ☐ Thin ☐ Thick ☐ Average ☐ Dry ☐ Oily ☐ Combo ☐ Reactive/Sensitive ☐ Uneven texture ☐ Lesions_____
☐ Pigment_____ ☐ Rash_____ ☐ Elastosis_____ ☐ Melasma _____
☐ Vascularity_____ ☐ Perspiration_____ ☐ Acne/Rosacea_____ ☐ Other _____
☐ Scarring_____ ☐ Enlarged pores_____ ☐ Striae _____

HEENT:

☐ Static Rhytids
☐ Dynamic Rhytids
☐ Eyelid Ptosis
☐ Eyebrow Ptosis
☐ Redundant eyelid skin
☐ Brow asymmetry
☐ Decreased brow projection/stability
☐ Infrabrow volume loss
☐ Temporal Hollowing
☐ Loss of volume/support temporal curve
☐ Forehead volume loss
☐ Volume loss superior nasal dorsum
☐ Volume loss lid/cheek junction
☐ Tear Trough
☐ Malar mounds
☐ Naso-jugal Fold
☐ Cheek deflation: _____ L _____ M _____DM
☐ Loss of O'Gee Curve
☐ Pronounced NLF
☐ Submalar volume loss
☐ Pre-auricular volume loss
☐ Ear lobe deflation
☐ Radial Cheek Lines
☐ Loss of mandibular definition
☐ Prominent Masseters
☐ Prominent Pre-jowl Sulcus
☐ Jowling
☐ Mentalis loss of support/projection
☐ Mentalis Peau d'orange
☐ Lip Atrophy
☐ Lip Asymmetry
☐ Flattening of Philtral Columns/Cupids Bow
☐ Loss of lower lip support corbel
☐ Elongated Philtrum
☐ White Roll Deflation
☐ Decreased Vermillion Border definition
☐ Loss of Lip Projection/Curve
☐ Oral Commissures
☐ Marionette Lines
☐ Preplatysmal Fat
☐ Necklace Lines
☐ Platysmal Banding
☐ Other_____



TRUNK:

☐ Excess adipose tissue ☐ Labial laxity ☐ Hyperpigmented/dyschromia
☐ Urinary stress incontinence ☐ Altered skin texture ☐ Other_____
☐ Skin laxity ☐ Cellulite

Extremities:

☐ Excess adipose tissue ☐ Skin laxity ☐ Hyperpigmented/dyschromia
☐ Volume loss of hands ☐ Altered skin texture ☐ Other_____

Comments:_____
_____

Assessment Diagnosis: ICD 10- L98.8: disorders of the skin and subcutaneous tissue, other
Plan of Treatment: Continued plan of care/treatments and assessment updates to MD/NP provided by Epicentre Patient Care Provider
Treatment: See Signed MD orders to include:

☐ Baseline Assessment Pictures

☐ HA fillers ☐ Coolsculpting ☐ Microneedling w/RF (Morpheus8) ☐ Ultherapy
☐ Biostimulatory Fillers ☐ Fractionated Laser ☐ RF (Thermage) ☐ miraDry
☐ Neuromodulator ☐ Ablative Laser ☐ Hydrafacial/Dermaplane ☐ Endermologie
☐ Kybella ☐ BBL ☐ Veingogh
☐ PDO Threads ☐ Microneedling ☐ Chemical Peel

Referrals/Follow-up: _____

Comments: _____
_____

Signature MD/NP_____ **Print Name**_____ **Date** _____

Annual Review: Date _____ Initial_____ Date _____ Initial_____ Date _____ Initial_____

Patient Care Provider Signature: _____

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Directed by Dallas Plastic Surgery Institute

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 _____

EPICENTRE SKIN CARE & LASER CENTER
9101 N. Central Expressway, Suite 500, Dallas, TX 75231 | 214-887-1577 | epicentreskincare.com

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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 _____

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PHOTO CONSENT

CONSENT FOR TAKING AND USE OF PHOTOGRAPHS, VIDEOTAPE, AND COMPUTER IMAGES

Requested by EpiCentre Skin Care & Laser Center/Dallas Plastic Surgery Institute

Patient Name *(please print)* _____DOB_____

I certify that I am the Patient or Legal Guardian of the above named patient, and hereby consent that photographs, videotapes, and/or computer imaging may be taken of the above named patient or parts of such patient's body under the following conditions and used for the following reasons:

1. The photographs, videotape, and/or computer imaging may be taken at the consent of such patient's physician/EpiCentre and shall be taken by the physician/EpiCentre or photographer approved by EpiCentre/physician.

2. I authorize EpiCentre/physician to use my photographs, videotapes, and/or computer images for the following educational and/or scientific purposes.

    - Lectures and presentations for an audience of medical professionals or for the general public
    - Medical, surgical, and scientific journal articles or books
    - Selected newspaper and magazine articles, as well as television programs
    - Patient education materials for EpiCentre/physician's office use
    - Patient/physician/EpiCentre education through Internet use

3. I understand that all photographs, videotapes, and/or computer imaging viewed, whether of the patient or other individuals, are demonstrative in purpose and are only a representation of the possible result that could be achieved through the proposed surgery. I further understand that imaging is used as an educational tool to benefit the patient and does not guarantee any result, since plastic surgery is both an art and a science.

4. I understand that the patient will not be identified by name, but that such photographs, videotapes, or computer images may reveal my identity. I accept this loss of anonymity.

5. This authorization is granted in furtherance of medical education, knowledge, research or the general public welfare, and as a voluntary contribution. I/we hereby waive all rights I/we might have to such photographs, videotapes, and/or computer imaging, and do hereby release, discharge and save harmless The Dallas Plastic Surgery Institute and its employees and agents from all claims and liabilities in law and in equity arising from such use.

Patient/Guardian Signature_____ Date_____

Relationship to patient: _____

Witness_____ Date_____

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