Cosmetic Client Profile

By completing this client profile, you will be helping us to correctly evaluate your skin care needs. All information will be kept in strict confidence.

Name: _____ Age: _____ Date of Birth_____

Contact info: Please circle your preferred contact # and/or method and circle if we may leave a message at each.

Address: _____
City: _____ ST: _____ Zip: _____
Home Phone: _____ Cell:_____ Work: _____
Email: _____ May we contact you via email? Y/N

How did you find out about us? _____
SS#:_____

Dates of upcoming special events?
_____

Please list any prior cosmetic procedures (both surgical and non-surgical) and dates:
_____
_____

Have you ever been treated by a dermatologist? Y/N

If yes, for what condition:
_____

Do you wear contact lenses? Y/N

Within the last YEAR have you taken or used the following?
Retin A: Y/N Accutane: Y/N
Which of the following would you like to discuss today or are interested in more information on?
(Check all that apply)
_____ Botox (Cosmetic) _____Facial Redness
_____ Facial fillers (Juvederm, Radiesse, Restylane) _____Brown spots
_____ Facial peel _____Sun damage
_____ Erbium Laser peel _____Broken capillaries
_____ Fractional CO2 laser peel _____Laser hair reduction
_____ Laser vein removal (facial, legs, feet, ankles) _____Shaving bumps/ingrown hair
_____ Laser rejuvenation procedures _____Skin toning or pore size reduction
_____ Kybella
_____ Brow lift _____Fine lines & wrinkles
_____ Neck lift _____Jane Iredale Makeup
_____ Face lift _____Obagi Skin care products
_____ Blepharoplasty (eyelid surgery – lower and/or upper) _____Skin care program / evaluation
_____ Rhinoplasty (nose surgery) _____Cool Sculpting
_____Ultherapy
_____Other

When was your last treatment/procedure?
_____

Please specify treatment type?
_____
I am here today because I am most concerned about:
_____
_____
_____
_____
Please check any of the following current of past medical conditions:
_____Lupus or other auto-immune deficiency _____Scars that turn white or brown
_____Currently pregnant _____Dark spots after pregnancy / skin injury
_____Bleeding Abnormalities _____HIV_____
_____Rheumatoid arthritis "Gold" therapy _____Hepatitis
_____Use of Accutane in last year _____Light sensitive epilepsy
_____Psoriasis or Vitiligo _____Hirsutism
_____Keloid or very thick scarring _____Transplant anti-rejection drugs
_____Pulmonary embolism/blood clot _____Diabetes
_____Implants (location: _____) _____Leg ulcer or phlebitis
_____Coumadin anti/clotting agents _____Polycystic ovarian disease (PCOD)
_____Cystic Acne
_____Herpes simplex or fever blisters
_____Other STD

Please check all that apply:

_____Waxing/plucking/electrolysis/w/in 4 weeks
_____Chemical peels, dermabrasion, laser resurfacing facelift
_____Tattoos / permanent make-up
_____Collagen injection (location: _____)
_____Spray tan (professional) in last 21 days
_____Self tan, tanning lotions/ sprays, tanning bed, sun exposure in last 14 days

Who can we notify in case of an emergency?

Name_____
Phone#_____Relationship_____

I, the undersigned, consent to treatment necessary for the care of the above named patient. I hereby authorize release of any or all medical records to the referring physicians, my insurance carriers, or those involved in payment of my account. I further acknowledge full financial responsibility for any services rendered and understand that payment of charges incurred in the office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to **Aaron M. Fletcher M.D PC**. In the event an account is not paid within 90 days, the undersigned agrees to pay all costs of collection including attorney's fees and hereby waives all rights of exemption under the Constitution of the State of Georgia.

CONSENT SECTION

I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing. I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request. I understand that I may revoke this consent at any time by signing a revocation request available through the office manager of this practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

Who can we disclose your medical information to?

On the lines below list the names of individuals that are allowed to know your medical information, be specific:

_____
_____
_____
_____

Patient Photograph Release Form

Patient's Name_____Date of Birth_____

Photograph Consent and Release I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of the **Georgia Center for Ear, Nose & Throat and Facial Plastics** medical staff. I hereby give my consent for **Georgia Center for Ear, Nose & Throat and Facial Plastics** to use the photographs under one of the following circumstances.

Please initial one of the following:

_____ **Internet:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at **Georgia Center for Ear, Nose & Throat and Facial Plastics**, can be used on the company's website in order to inform the public about plastic surgery methods. Further, I release and discharge **Georgia Center for Ear, Nose & Throat and Facial Plastics**, any employees of **Georgia Center for Ear, Nose & Throat and Facial Plastics**, and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

_____ **All Media:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at **Georgia Center for Ear, Nose & Throat and Facial Plastics** can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about plastic surgery methods. Further, I release and discharge **Georgia Center for Ear, Nose & Throat and Facial Plastics**, any employees of **Georgia Center for Ear, Nose & Throat and Facial Plastics** and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with **Georgia Center for Ear, Nose & Throat and Facial Plastics**. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at **Georgia Center for Ear, Nose & Throat and Facial Plastics**.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

_____ _____

Signature (Patient or Parent/Guardian if Patient is under 18) **Date**

Facial Plastic Financial Agreement Form

Patient Name:_____ DOS:_____
Area of Concern:_____
Product Preference:_____
Total Units/Viles &
Price:_____
_____
_____
_____

Facial Plastic Code/Codes:

_____

Payment Type: Credit / Care Credit / Cash / Check

Consult Fee:_____ Date:_____

Total Fees:_____**Balance Due:**_____
1st Payment: _____ Date:_____
2nd Payment: _____ Date:_____
3rd Payment: _____ Date:_____

Paid in Full: Yes or No Date:_____

Financial Agreement:
The total amount or 50% percent of the total is due upon scheduling your procedure. The remaining balance, if any, is due 24 hours before the procedure date.

Signature:_____ **Date:**_____

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