Smartlipo™ // BBL Consult

Please print

Name: _____ Date: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: (Home)_____ (Work) _____

Cell/Preferred Contact Number: _____

Email: _____

How did you hear about our services (website, Facebook, Instagram? Were you referred to our center?

If yes, by whom**:**_____

Desired Treatment Area(s)? _____

_____

Male ___ Female ___ **Age?** _____

Height _____ Weight _____(**provided by staff)** BMI_____ **(provided by staff)**

Are you Pregnant? Yes _____ No _____

Have you had any previous liposuction surgery? Yes _____ No _____

Do you wish to treat Cellulite? _____ Stretchmarks _____ or Scars _____

Comments: _____

_____

What is your budget?

- ❑ **$2,000 - $5,000 (ONE TO TWO AREAS)**
- ❑ **$5,000 to $7,000 (TWO TO THREE AREAS)**
- ❑ **$7,000 to $10,000** (**THREE TO FOUR AREAS**)
- ❑ Do you plan to finance your surgery? We accept Care Credit, (6 to 48 months financing; you select the terms for repayment), United Medical Credit and Lending USA. Credit score check is conducted by the lending companies. Go their website for details.
- ❑ We accept all major credit cards: VISA, MasterCard, American Express, Discover, Diner's Club

Patient History – please print

Patient Name: _____ Date of Birth: _____

*Date of Patient Examination: _____ *Date of Proposed SmartLipo: _____

Date of Last Complete Physical: _____Date of EKG/ECG: _____

A current physical is required for surgery. **PHYSICAL MUST BE WITHIN 12 MONTHS OF YOUR SELECTIVE SURGERY DATE**. Contact your physician to fax a copy to our office. EKG/ECG required if 50 years or previous cardiology issues (includes hypertension).

Date of Last Menstrual Cycle (females only): _____ If not applicable, state why: hysterectomy, menopause, tubal ligation: _____

Please check the areas you are considering:

- ❑ Arms (upper)
- ❑ Arm pit (Hyperhidrosis – sweat glands)
- ❑ Bra, Above (Above the bra)
- ❑ Bra, Under (Under the bra)
- ❑ Abdomen, Upper _____Elasticity
- ❑ Abdomen, Upper (half-moon)
- ❑ Abdomen, Lower _____Elasticity
- ❑ Love Handles
- ❑ Back/Flanks
- ❑ Upper Shelf of Buttocks ("butt enhancement")
- ❑ Buttocks Reduction /// Buttocks Fat Transfer/**BBL** _____Elasticity
- ❑ Knees
- ❑ Saddle Bags
- ❑ Thighs, Partial Inner (Upper 4 inches)
- ❑ Thighs, Full Inner
- ❑ Thighs, Front
- ❑ Thighs, Back
- ❑ Male Breast Reduction
- ❑ Chin
- ❑ Cellulite: ❑ Stage 1:_____ ❑ Stage 2: _____ ❑ Stage 3: _____

How much improvement in contouring and body change are you expecting?

❑ 99% - 80% ❑ 80%-60% ❑ 60%-40% ❑ 40%-20%

Patient History – **please print**
It is imperative you provide all of your medical history during your consult.
Your consult form will be screened to determine if you are eligible for this procedure.
Be honest to receive the best and safest treatment possible.

What is your Physician name/address/phone number: _____

_____

If a medical condition exists, your physician may be contacted.

Have you ever had liposuction or reconstructive surgery before? ❑ YES ❑ NO

List all areas and year: _____
_____

Do you keloid? ❑ YES ❑ NO (heavy scarring, overgrowth of tissue; typically seen in African Americans). Our laser technician can treat **surgical scars** 30 days post-surgery. General fees will be listed on your cost sheet.

Do you smoke? ❑ YES ❑ NO List:_____

Do you bruise easily? ❑ YES ❑ NO

Do you have any bleeding problems (ie anemia)? ❑ YES ❑ NO Please list: _____.

Do you take Iron supplement? ❑ YES include dosage _____ ❑ NO

Do you have any known allergies? ❑ YES ❑ NO If yes, please list example, latex, tape, penicillin, aspirin, sulfa, codeine, etc. _____
_____

Do you have or have you had in the past any problems taking medications? Allergy or adverse reactions?
❑ YES ❑ NO If yes, which ones? Include anesthesia and medications
_____

Do you have any kidney, heart, thyroid, diabetes, circulation, metabolic, blood pressure or any other diseases or problems? ❑ YES ❑ NO Which ones? _____

List **ALL** **Current Medications** & Vitamins/Supplements in the last 6 months including Aspirin, Coumadin, Excedrin, Motrin or anything which thins the blood, including Vitamin E and Herbal Medications (Garlic, Ginger, Ginseng, Ginko)?

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

If necessary, write additional medications on this line: _____

Current Medical Problems:

1. _____
2. _____
3. _____
4. _____

Patient History – please print

Any Blood Transfusions: ❑ YES ❑ NO If yes, why: _____

Have you ever been exposed to or do you have any contagious diseases (for example Hepatitis, AIDS, HIV, STD, etc)? ❑ YES ❑ NO Which ones? _____

List Past Surgeries: _____

_____

Overnight stays in hospital – include month and year of hospitalization (to include child birth/deliveries)

_____

_____

If you have ever been pregnant, how many deliveries? _____ Any C-sections? ❑ YES ❑ NO

Any recent miscarriages or abortions, if so when: _____

We ask this question because a false positive pregnancy test will postpone your surgery. We cannot operate on a positive pregnancy regardless of the type of termination until we receive a negative test result.

Have you been treated for any depression, emotional or psychiatric problems? ❑ YES ❑ NO

If yes, are you currently under care? With or without medication? List medications: _____

_____

Have you ever been in recovery or been addicted to any substance? ❑ YES ❑ NO Which ones?

_____

What are your main concerns about SmartLipo?_____

_____

Do you understand the procedure, risks, expected outcomes, Pre & Post SmartLipo instructions and the importance of follow up care? ❑ YES ❑ NO

If no, what are you still unclear about? _____

Have we now clarified and answered all your questions? ❑ YES ❑ NO

Your signature verifies that you are clear about this procedure.

Any failure to provide an accurate medical profile/history may result in our refusal of providing you services. Your information will be held in accordance with HIPPA – patient privacy act.

_____ _____

Signature Date