THE MEDSPA AT INNOVATIVE SURGICAL ARTS

Patient Name: _____ Date: _____

Date of Birth: _____ Sex: □Male □ Female

Address: Email Address: _____

City: _____ State: _____ Zip: _____ Preferred Phone: _____

Emergency Contact: _____ Phone #: _____

How did you hear about us?	
□ Friend or Family?	Name:
□ The internet	Specify Site:
□ Advertisement	Specify Ad:
□ Employee	Name:
□ A Physician	Name:
□ Employer	Name:
□ Other	Name:

Concerns and Procedures or Products of Interest to You

□ Liposuction/Liposculpture	□ Scar Revision/ Beautification	□ Micro-dermabrasion
□ Panniculectomy (removal of excess skin)	□ Snapback Package	□ Hyperpigmentation
□ Tummy Tuck	□ Injectable Fillers/Botox	□ Chemical Peels
□ BBL ("Booty Pop")	□ Gynecomastia (man boobs)	□ Uneven Skin Tone
□ Vaginoplasty/Labiaplasty	□ Wrinkles	□ Mole Removal
□ Vaginal Tightening	□ Skin Care Products	□ Enlarged Pores
□ Breast Augmentation	□ Hair Removal	□ Hair Loss Treatment
□ Fat Transfer (face/breasts)	□ Acne	□ Botox/Fillers
□ Mommy Makeover	□ Weight-loss	□ O Shot/P Shot
□ Scarless Breast Lift/Reduction	□ Split Earlobe Repair	□ Other

3200 Highlands Parkway Suite 420 Smyrna, GA 30082
Phone: 678-505-0029 Fax: 678-424-1127

Do you or have you had any of the following conditions?

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Auto Immune
- ☐ Asthma
- ☐ Bleed Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Eczema
- ☐ Fainting
- ☐ Gestational Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Infection (Active)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Melanoma
- ☐ Nervous Disorder
- ☐ Pigmentation Disorder
- ☐ Pre-Diabetes
- ☐ Psoriasis
- ☐ Respiratory Issues
- ☐ Skin Conditions
- ☐ Stroke
- ☐ Thyroid Disease

Allergies:_____

Medications: _____

Cosmetics:_____

Latex/Other:_____

Have You ever or are you using:

Retin-A, Renova, Retinoic Acid	YES	NO
Accutane	YES	NO
Prescription Acne Medication	YES	NO
Birth Control Pills	YES	NO
Steroids	YES	NO
Chemotherapy	YES	NO
Radiation Treatment	YES	NO
Pacemaker/Internal Defibrillator	YES	NO

List all medications/supplements you are currently taking, oral and/or topical (including aspirins)

_____

_____

Are you currently:

Pregnant	YES	NO
Breastfeeding	YES	NO
Tanning	YES	NO
Smoking (vaping/marijuana)	YES	NO

Other:

_____

Previous Procedures (if YES list date)

Chemical Peel	YES	NO
Injectables/Fillers	YES	NO
Hair Removal	YES	NO
Cosmetic Surgery	YES	NO
Laser Surgery	YES	NO
Silicone Injections	YES	NO

Have you ever had:

Cold Sores	YES	NO
If yes, frequency	<1/year	1-2/year	2-5+/year

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Art.....Defying Gravity

Photo/Video Consent

I, _____, give my informed and voluntary consent to Melinda Miller-Thrasher, M.D. and/or his associates to take photographs and/or videos of me pre-operatively, intra-operatively, and post-operatively.

I authorize the use and disclosure of: (Please check all that apply)

- o My name
- o My photographic/video images taken pre-operatively, intraoperatively, and post-operatively
- o My testimonial

I understand that the information will be shown on television, social media, and on the practice website to show the transformation process to the general public, which includes current and prospective patients. All pictures will remain anonymous and any identifying feature will be blurred out as best as possible. However, I also understand that in some rare circumstances the photographs and/or videos may display features that identify me.

I understand entirely that this authorization is completely voluntary. I understand that any disclosure of information pursuant to this consent has the potential of re-disclosure and may no longer be protected by HIPAA privacy regulations and any other applicable federal and/or state confidentiality rules. Dr. Melinda Miller-Thrasher and/or his associates will not be liable should you disclose any identifying factors to a third party, as they may not be required to maintain your privacy.

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects the disclosure moving forward and is not retroactive. This authorization expires 99 years from the date signed.

I understand that the practice cannot condition treatment on whether I sign this authorization.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my information. By signing this consent, I hereby, knowingly and voluntarily authorize Melinda Miller-Thrasher, M.D., to use my photograph(s) and videos in the manner described above.

☐ Yes, I would like a copy of this form. Copy provided _____

Signature _____ Date _____

Relationship to Patient: _____