



Patient Information Form

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Phone Carrier: _____

DOB: _____ Age: _____ Gender: _____ Marital Status: _____

Social Security Number: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about our clinic?

- | | | |
|--|---|--|
| <input type="checkbox"/> DrMMacdonald.com | <input type="checkbox"/> Facebook | <input type="checkbox"/> Dr. Referral: _____ |
| <input type="checkbox"/> SanFranciscoSnoring.com | <input type="checkbox"/> Twitter | <input type="checkbox"/> Seminar: _____ |
| <input type="checkbox"/> RealSelf | <input type="checkbox"/> Yelp | <input type="checkbox"/> La Belle Spa: _____ |
| <input type="checkbox"/> Google | <input type="checkbox"/> Yellow Pages (city): _____ | <input type="checkbox"/> Beauty Network: _____ |
| <input type="checkbox"/> Patient Referral: _____ | <input type="checkbox"/> Friend / Family: _____ | <input type="checkbox"/> Original Skin: _____ |
| <input type="checkbox"/> Other: _____ | | |

What is the nature of your visit?

SURGICAL		LASER/SKIN CARE	
<input type="checkbox"/> Eyelid Surgery	<input type="checkbox"/> Brow lift	<input type="checkbox"/> Facial Rejuvenation	<input type="checkbox"/> Wrinkles
<input type="checkbox"/> Facelift	<input type="checkbox"/> Mid-face Lift	<input type="checkbox"/> Red Spots	<input type="checkbox"/> Age Spots/brown spots
<input type="checkbox"/> Cheek/Chin Implant	<input type="checkbox"/> Liposuction	<input type="checkbox"/> Facial Veins	<input type="checkbox"/> Chemical Peels
<input type="checkbox"/> Nasal Surgery	<input type="checkbox"/> Otoplasty	<input type="checkbox"/> Skin Resurfacing	<input type="checkbox"/> Leg Veins
<input type="checkbox"/> Mole removal	<input type="checkbox"/> Excision & Scars	<input type="checkbox"/> Skin Tightening	<input type="checkbox"/> Medical grade products
INJECTABLES/FILLERS		SNORING TREATMENT	
<input type="checkbox"/> Botox / Dysport	<input type="checkbox"/> Restylane / Perlane	<input type="checkbox"/> Snoring Treatment	
<input type="checkbox"/> Juvederm/Voluma	<input type="checkbox"/> Radiesse	<input type="checkbox"/> Obstructive Sleep Apnea Treatment	
SUPPLEMENTS			
<input type="checkbox"/> Anti-Aging		<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Performance Enhancing

Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? No Yes, please list:



Section I: Surgery and Anesthesia History

1. Have you ever had surgery? No Yes, please describe:

2. Have you or a blood relative had complications with anesthesia? No Yes, please describe:

Section II: Specific Medical History

1. Are you pregnant? No Yes Maybe/trying

Height: _____ Weight: _____

2. Asthma or Lung Disease

3. Migraine Headaches

4. High Blood Pressure

5. Heart Trouble

6. Hepatitis or Liver Trouble

7. Kidney Disease

8. Diabetes

9. Problem Scarring

10. **Other medical problem(s) that we should know about:**

No	Yes	Description
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

Section III: Social History

1. Do you smoke? No Yes, how much? _____

2. Do you drink? No Yes, how much? _____

3. Do you have children? No Yes, how many? _____

Section IV: Family History

Please list any significant or relevant family medical problems:



Section V: Medications

Are you taking any medications, vitamins or herbal supplements? No Yes, please list:

Emergency Contact

Name: _____ Relationship: Spouse Parent/Guardian Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Insurance Information

If applicable, please state the name of your insurance company: _____
(Health information is released to your insurance company with your permission only)

Financial Policy/Cancellation Policy

CANCELLATIONS: Please be advised that we have a cancellation fee of **\$100** for missed appointments or cancellations not received 48 hours prior to your appointment. We understand that emergencies do arise; however we request at least 48 hour notice for rescheduling or canceling all appointments. Failure to do so may result in your account being charged. Informing us of your cancellation allows us to fill your reserved time. **NO SHOWS WILL BE BILLED THE CANCELLATION FEE.**

Treatments: All treatments, procedures or pre-paid packages are non-refundable. Packages must be used within one year from the date of purchase. Credit from pre-paid treatments, procedures and/or packages may be applied toward other forms of treatment(s) or product(s) only at management's discretion. Credit can only be given to and used by purchaser. **NO REFUNDS. EXCHANGES ONLY.**

Appointments: We recommend that you make your next appointment prior to leaving our office. This is particularly important if you are having a series of treatments over a defined period of time.

Arrivals: Please arrive for your appointment in our office on time. This ensures that you will receive the required amount of time you deserve for your treatment and helps us to not intrude on the following patient's reserved time.

I have read this questionnaire, I understand the cancellation policy and I have disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

Receipt of Notice of Privacy Practices (also available at www.DrMMacdonald.com)

I have received a copy of Aesthetic Surgery Center's Notice of Privacy Practices.

Patient Signature: _____ Date: _____



Consent to Communicate

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
<input type="checkbox"/> Call Work Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Call Cell Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Call Home Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Send Email	-	-	<input type="checkbox"/>	-
<input type="checkbox"/> Email Appt Reminders				
<input type="checkbox"/> Email Medical Info				
<input type="checkbox"/> Email Marketing Info				
<input type="checkbox"/> Send Regular Mail	-	-	<input type="checkbox"/>	-
Mail to which Address: <input type="checkbox"/> Home <input type="checkbox"/> Other (please list):				
<input type="checkbox"/> Send Text Page	-	-	<input type="checkbox"/>	-
<input type="checkbox"/> Text Appt Reminders – if so, list cell carrier:				
<input type="checkbox"/> Text Marketing Info – if so, list cell carrier:				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Signature: _____

Date: _____