AN AFFILIATE OF PLATINUM DERMATOLOGY NETWORK™

Cosmetic Consultation

PATIENT INFORMATION:

Name: _____ ___ Home #: (_____) _____ - _____

Address: _____ Cell #: (_____) _____ - _____

City: _____ State: _____ Zip: _____ E-mail: _____

DOB: _____/_____/_____ Age: _____ Sex: M / F Married: Y / N

Spouse Name: _____ SSN: _____/_____/_____

Driver's License #: _____ Occupation: _____ City: _____

Employer: _____ Work #: (_____) _____-_____

NEXT OF KIN/FRIEND NOT LIVING WITH YOU:

Name: _____ Relationship: _____ Phone #: (____) _____-_____

IF PATIENT IS A MINOR, PLEASE COMPLETE:

Name of Parent/Guardian: _____ Phone #: (____) _____-_____

Employer: _____ Work #: (____) _____-_____

DID A PHYSICIAN REFER YOU? Y/ N

☐ Physician Name: _____ Tel #: (_____) _____-_____

Address: _____ City: _____ State: _____

IF NOT, HOW DID YOU HEAR ABOUT US?

☐ Friend/Family ☐ Saw our sign ☐ Insurance Company ☐ Google ☐ Magazine

☐ Yellow Pages ☐ Mailing ☐ Ad online ☐ Facebook ☐ Instagram ☐ Our Website

☐ Other: _____

INSURANCE/PAYMENT INFORMATION (if not self):

Insured Person's Name: _____ Relationship: _____

DOB: _____/_____/_____

NOTICE REGARDING PAYMENTS/INSURANCE CLAIMS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required on the day the service is provided. The exact payment amount cannot be determined with complete accuracy until the claim is submitted to your insurance company. Your payment will be based on your individual health plan, deductible and/or coinsurance. Procedures and evaluations, which are excluded from coverage including cosmetic procedures (benign mole removal, skin tag removal, cosmetic procedures, etc.) and cosmetic evaluations, based on your plan's determination of medical necessity, will also be your responsibility. Your office co-pay is due at the time of the visit and, in most cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance usually apply. For all other patients, payment in full is required at the time of service. Standard office policy requires that you must present your drivers' license (or ID), insurance card (if applicable) and a credit/debit card for verification and for our records.

I have read the above information and understand that I am responsible for payment of services I receive.

Patient / Guardian Signature: _____ Date: _____

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Name _____

Do you have a history of:

☐ Cataracts ☐ Cancer ☐ Osteoarthritis ☐ Osteoporosis ☐ Glaucoma ☐ Asthma

☐ Diabetes ☐ Hay Fever ☐ Asthma ☐ HIV/AIDS ☐ Kidney Disease ☐ Thyroid Disease

☐ Heart Disease ☐ Liver Disease ☐ Blood Pressure ☐ Nail Disorder ☐ Epilepsy

☐ Acid Reflux ☐ Cholesterol ☐ Pacemaker/defibrillator

☐ Currently Pregnant Due Date: _____/_____/_____ ☐ Currently Breastfeeding

Do you have a history of cold sores (herpes simplex)? ☐ Yes ☐ No

Circle one: Smoke: Yes / No Drink Alcohol: Yes / No If yes, how many/wk? _____

Have you had *any* recent tanning bed or sun exposure (past 4 weeks)? Yes / No

Which best describes your skin type (check one box only)?

☐ Always burns, never tans

☐ Burns easily, tans poorly

☐ Tans after initial burn

☐ Burns minimally, tans easily

☐ Rarely burns, tans darkly easily; Moderately pigmented (Hispanic, Asian, Mediterranean, light skin African-American)

☐ Never burns, always tans darkly; Darkly Pigmented (African-American)

Which treatments are you interested in? (check all that apply) ☐ Microdermabrasion

☐ Chemical Peels ☐ Laser Hair ☐ Fotofacials ☐ Skin Resurfacing ☐ Waxing

☐ Coolsculpting ☐ Laser Pen Therapy ☐ Other _____

What are your cosmetic concerns (check all that apply)?

☐ Brown spots ☐ Skin discoloration ☐ Redness ☐ Facial Veins ☐ Leg Veins ☐ Scarring

☐ Breakouts ☐ Skin Texture ☐ Fine lines/wrinkles ☐ Skincare regimen ☐ Weight loss

Please check any of the following you are currently using?

☐ Retin-A/Tretinoin ☐ Glycolic Acid/Alpha-hydroxy acid ☐ Accutane (within last year)

☐ Vitamin C ☐ Zovarix/Famvir/Acyclovir/Valtrex ☐ Hormone replacement ☐ Birth Control Pills

☐ Antibiotics ☐ Skin lightening products

☐ Acne medications (Which ones _____)

Medication/Product Allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Please list your current skin care regimen:

AM _____ PM _____

_____ _____

_____ _____

_____ _____

_____ _____