



Cosmetic Questionnaire

Date: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Home Phone#: \_\_\_\_\_
first middle initial last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SS#: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Please Circle: Married/Single Sex \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Patient/Parent Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

MEDICAL INFORMATION

Who referred you (ie doctor, friend, ER): \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician Name & Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for Consultation: \_\_\_\_\_

List All Drug Allergies (Including Latex): \_\_\_\_\_ Past Surgeries: \_\_\_\_\_

Current Medications (including aspirin & supplements): \_\_\_\_\_

Medical History

Any Personal History of:

- Heart Disease, Diabetes, High Blood Pressure, Asthma, Liver Disease, Kidney Disease, Alcohol Abuse, Pacemaker / AICD, DVT / PE, Bleeding Disorder, Hepatitis, HIV / AIDS, Smoking, Poor Circulation, Anemia, Other (Please List), Psychiatric Care, Depression, Chemical Dependency, Eating Disorder, Anxiety / Panic Disorder, Obsessive Compulsive Disorder, MRSA Infection. Includes Yes/No checkboxes and Height/Weight fields.

Has your weight remained stable or have you experience recent changes in weight? \_\_\_\_\_

Do you exercise? (If yes, what types of exercise do you do?) \_\_\_\_\_

Do you maintain a healthy diet? \_\_\_\_\_

Smoking History: None Active Social Previous

If active smoking history, how much and how often do you smoke? \_\_\_\_\_



## Cosmetic Questionnaire

### INSURANCE/BILLING INFORMATION

Primary Insurance Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Claim Address: \_\_\_\_\_ Identification #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscribers Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Secondary Insurance Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Claim Address: \_\_\_\_\_ Identification #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscribers Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Birth date: \_\_\_\_\_

### Areas of Focus

In order of importance, what are your main concerns? (In your own words – state your concerns in regards to specific areas.)

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_
5. \_\_\_\_\_  
\_\_\_\_\_

### Breast Consultation

What are your main concerns regarding your breasts?  
\_\_\_\_\_

What is your current bra size? \_\_\_\_\_ Do you have a desired bra size? \_\_\_\_\_

Do you currently have breast implants? \_\_\_\_\_

If yes, do you have saline or silicone implants? \_\_\_\_\_

Are you consulting to remove or replace your current implants? \_\_\_\_\_

Have you had any prior breast surgeries or biopsies? \_\_\_\_\_



## Cosmetic Questionnaire

Have you had a recent mammogram? \_\_\_\_\_

Do you have any personal history of breast cancer? \_\_\_\_\_

Do you have any family history of breast cancer? \_\_\_\_\_

Breastfeeding:            Never            Currently            Previously            Future

### **Breast Augmentation Questions:**

Do you have a preference between silicone or saline implant?

\_\_\_\_\_

Do you have a preference of implant placement (under the muscle or over the muscle)?

\_\_\_\_\_

Do you have a preference related to incision site (Inframammary fold (under breast in crease) or around nipple)?

\_\_\_\_\_

Do you believe your breasts "sag"? \_\_\_\_\_

Do you have stretch marks on your breasts? \_\_\_\_\_

Do you believe your breasts and/or nipples are symmetrical? \_\_\_\_\_

### **Body Consultation**

What are your main concerns regarding your body?

\_\_\_\_\_

Please circle all that apply to you:

Excess Fat            Excess skin/loose skin            Lack of Muscle Tone            Stretch Marks

Do you have a c-section scar or any other scars? \_\_\_\_\_

Do you have a hernia (past or present)? \_\_\_\_\_

### **Facial Consultation**

Have you had any previous facial procedures (including botox, fillers, etc.)?

\_\_\_\_\_

Do you currently maintain a skin care regimen? If yes, what does that consist of?

\_\_\_\_\_



## Cosmetic Questionnaire

What are your main concerns regarding your face? Are there specific areas of concern (jowls, eyes, nose, etc.)? \_\_\_\_\_

Please check all that apply to you:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asymmetry                                       | <input type="checkbox"/> Brown Spots / Red Spots | <input type="checkbox"/> Lines and Wrinkles     |
| <input type="checkbox"/> Lack of volume<br>(Flat face/Hollow under eyes) | <input type="checkbox"/> Loose / Hanging Skin    | <input type="checkbox"/> Scars                  |
|  | <input type="checkbox"/> Skin Laxity             | <input type="checkbox"/> Tone / Texture of Skin |

### **OFFICE POLICIES FOR: Advanced Plastic Surgery Center (PLEASE READ AND SIGN)**

• With my consent, Dr. Chang, Dr. Thornton, and their office staff may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). I also authorize them to call my home or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With this consent, Dr. Chang and Dr. Thornton may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements. By signing this form, I am consenting to Dr. Chang and Dr. Thornton's use and disclosure on my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Chang and Dr. Thornton may decline to provide treatment to me. I hereby authorize Dr. Chang and Dr. Thornton to treat me or my child by medical means they deem necessary or advisable. I further authorize payment of my medical benefits to Dr. Chang or Dr. Thornton. I understand that above guidelines, have had the opportunity to ask questions, and will be given a copy of the privacy notice if I request it. Name of Person(s) we can disclose information to: \_\_\_\_\_

- In order to treat you as a patient and submit your claims to the proper insurance company, this information sheet must be **completely** filled out.
- This office must be supplied with all the necessary referrals and completed claim forms at the time of your visit. It is the responsibility of the patient to make sure your visits are authorized by your insurance company. If your insurance company requires referrals/authorizations from your primary care physician, this office must receive the authorization/referral within 10 days. After 10 days, you will be responsible for all bills.
- Payment for all office visits must be made at time of service. If you are involved in a legal matter, payments must still be received on a monthly basis to keep your account in good credit.
- This office allows 60 days after insurance has been filed for the insurance company to make a payment or to receive a response. After this time, the patient is responsible for making payments on the balance and also actively pursuing the insurance company to find out the delay in payment.
- Photos taken are the property of Advanced Plastic Surgery Center. Photos may be released to your insurance company to determine medical necessity.
- Work injuries will be filed to the workers' compensation carrier that has been provided to you. However, any balance not paid by your workers' compensation carrier will be billed to you directly and will be your responsibility.

Patient/Parent Signature: \_\_\_\_\_