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	☐ **Yes**	☐ **No**	**DVT / PE**	☐ **Yes**	☐ **No**	**Psychiatric Care**	☐ **Yes**	☐ **No**
Diabetes	☐ **Yes**	☐ **No**	**Bleeding Disorder**	☐ **Yes**	☐ **No**	**Depression**	☐ **Yes**	☐ **No**
High Blood Pressure	☐ **Yes**	☐ **No**	**Hepatitis**	☐ **Yes**	☐ **No**	**Chemical Dependency**	☐ **Yes**	☐ **No**
Asthma	☐ **Yes**	☐ **No**	**HIV / AIDS**	☐ **Yes**	☐ **No**	**Eating Disorder**	☐ **Yes**	☐ **No**
Liver Disease	☐ **Yes**	☐ **No**	**Smoking**	☐ **Yes**	☐ **No**	**Anxiety / Panic Disorder**	☐ **Yes**	☐ **No**
Kidney Disease	☐ **Yes**	☐ **No**	**Poor Circulation**	☐ **Yes**	☐ **No**	**Obsessive Compulsive Disorder**	☐ **Yes**	☐ **No**
Alcohol Abuse	☐ **Yes**	☐ **No**	**Anemia**	☐ **Yes**	☐ **No**	**MRSA Infection**	☐ **Yes**	☐ **No**
Pacemaker / AICD	☐ **Yes**	☐ **No**	**Other (Please List)**	________________________				
Height:	______________		**Weight:**	______________				

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 (Infamammary 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:

- ☐ Asymmetry
- ☐ Lack of volume (Flat face/Hollow under eyes)
- ☐ Brown Spots / Red Spots
- ☐ Loose / Hanging Skin
- ☐ Skin Laxity
- ☐ Lines and Wrinkles
- ☐ Scars
- ☐ 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 our 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: ____