BROWN
PLASTIC SURGERY

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Patient Information Form

Today's Date: _____

First Name: _____ M.I. _____ Last Name: _____

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

Date of Birth: _____ Age: _____ Gender: Male Female Other

Home Tel: _____ Work Tel: _____Mobile Tel: _____

E-mail: _____

Preferred Contact Method? (circle) Home Phone Work Phone Cell Phone

Ok to leave a message on Home Phone? Yes / No Ok to leave a message on Cell Phone? Yes / No

Ok to email you specials/flyers? Yes / No Ok to Text? Yes / No

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Reason for Visit: _____

REFERRAL SOURCE: How did you hear about Skyler?

Instagram Google RealSelf Yelp Facebook Other: _____

Keywords Used: _____ Patient Referral: _____

EMERGENCY CONTACT INFORMATION

Name: _____Phone: _____Relationship: _____

Scottsdale: 11000 N Scottsdale Road, Ste 100, Scottsdale, AZ 85254
Sun City: 13640 N 99th Ave, Ste 400, Sun City, AZ 85351
Phone: 480.947.2455 Fax: 480.947.2456

Patient Health History

Patient Name: _____ **Height:** _____ **Weight:** _____

Allergies/Medications

Are you allergic to any medications or local anesthetics? Yes / No

If yes, please list: _____

Do you have any food or drink allergies? Yes / No

If yes, please list: _____

Are you currently taking any medications or supplements? Yes / No

If yes, please list ALL medications that you are currently taking or have taken within the last 7 days. This includes prescriptions, over-the-counter medications, vitamins, and supplements (internal or topical).

_____

Do you pre-medicate for any medical procedures (such as: prescribed antibiotics)? Yes / No

Are you currently taking, or have you completed Accutane therapy? Yes / No

If yes, when? _____

Social History

Do you drink alcohol? Yes / No If yes, how often: _____

Do you smoke? Yes / No If yes, how often: _____

For Women Only

Are you pregnant? Yes / No

Are you trying to become pregnant? Yes / No

Are you nursing? Yes / No

Health History Continued

Have you had any dental work, vaccines, UTIs, or other active infections within the last four weeks? Yes / No

If yes, please list and include dates: _____

Is there a history of raised scarring (keloid) after injury or surgery? Yes / No

Do you bleed easily? Yes / No

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

☐ Denies Past Medical History	☐ Neuromuscular Disorder, type: _____
☐ Emphysema	☐ Kidney Stones
☐ Asthma	☐ Skin Cancer
☐ Breast Cancer	☐ Skin Disease
☐ Cancer (Other)	☐ Stroke
☐ Heart Attack	☐ Thyroid Disease
☐ Diabetes	☐ Tuberculosis
☐ Facial Implant	☐ Stomach Ulcers
☐ Seizure Disorder	☐ Bleeding Disorder
☐ Heart Disease	☐ Auto Immune Disorder, type:_____
☐ Heart Murmur	☐ Arthritis, type: _____
☐ Hepatitis	☐ Other _____
☐ High Blood Pressure	☐ Other _____

List any surgical procedures you have had, and date of:

_____

_____

Areas of Concern

Please check all that apply or that you may have questions about.

- Frown lines ☐
- Laughter lines (crow's feet) ☐
- Hollowness under eyes ☐
- Glabellar lines (number 11's) ☐
- Eyebrow lift ☐
- Nasalis (bunny lines) ☐
- Loss of volume in cheeks ☐
- Thins lips ☐
- Gummy smile ☐
- Downturned mouth ☐
- Ear lobe correction ☐
- Marionette lines ☐
- Jawline ☐
- Mentalis (pebble/cellulite/pitted chin) ☐
- Platysmal bonds ☐

- Uneven skin tone ☐
- Dry, dull skin ☐
- Age spots ☐
- Acne scars ☐
- Hair loss ☐
- Skin Care Regimen ☐

Other areas of concern or anything else you would like Skyler to address:

_____

_____

Products you are currently using:

_____

_____

Patient Photo Consent Form

I, _____, _____ consent to all medical images and / or
First Name, Last Name Date of Birth
videos being made of me or my child / dependent, not limited to one date of service.

I agree that the images and / or videos may be used for:
(Please circle Yes or No below to show consent type)

Medical documentation purposes (mandatory if receiving treatment)	Yes / No
In-office before and after book	Yes / No
Website and social media	Yes / No

I further acknowledge that there were no promises of compensation for such use of medical photos and / or videos taken by Brown Plastic Surgery. This consent may be revoked at any time with written request from patient.

By signing below, I confirm that I understand this consent form.

_____ _____
Signature of Patient / Parent or Guardian Date

_____ _____
Signature of Doctor / Healthcare Professional / Staff Date

Acknowledgment of Receipt of Privacy Notice

I attest the medical information provided is current and accurate to the best of my knowledge. I understand the signed copy of the privacy policy will be placed in my chart indicating that I have read, understood and agree to this policy. A copy of this may be obtained at any time upon your request.

I acknowledge that I have received a copy of the office's **Notice of Privacy Policies.**

_____ _____

Signature of Patient / Parent or Guardian Date

_____ _____

Printed Name (If Signed on Behalf of the Patient) Relationship Date

☐ **Please check here if you would like a copy of our Notice of Privacy Policies.**

Statement of Financial Responsibility

I understand that payment for services, whether cosmetic or not, is solely the responsibility of the patient or their guarantor.

_____ _____

Signature of Patient / Parent or Guardian Date

_____ _____

Printed Name (If Signed on Behalf of the Patient) Relationship Date