STATESBORO PLASTIC SURGERY

(912) 681-3330

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Age _____ Birthdate _____ SS# _____ Gender ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

How did you hear about us? (Mark all that apply)

❒ TV News ❒ TV Ad ❒ Phone Book ❒ Magazine ❒ Newsletter ❒ Seminar ❒ Salon ❒ Web

❒ Friend/Relative: _____ ❒ Doctor: _____ ❒ Other: _____

Past Medical Information

List all medications that you are presently taking:

_____

_____

List any over-the-counter medications (vitamins, herbal supplements, aspirin, etc) that you take regular:

_____

_____

Are you using any blood/skin thinning products and /or drugs? □ Yes □ No

Have you ever had an allergic reaction to any of the following? □ Cosmetics □ Medicines □ Food □ Animals □ Sunscreens

□ Iodine □ Pollen □ AHA's □ Fragrance □ Shellfish □ Latex □ Drugs If yes, please explain:_____

_____

Are you pregnant or trying to become pregnant? □ Yes □ No

Are you taking any oral contraceptives? □ Yes □ No

Any recent changes to or from your contraceptive treatment? □ Yes □ No If yes, what and when:_____

_____

Do you have problems regarding menopause? □ Yes □ No

Do you wear contact lens? □ Yes □ No

Do you smoke? □ Yes □ No

What is your stress level? □ High □ Meduim □ Low □ None

Have you ever used any acne medications? □ Yes □ No If yes, when _____ and which drug_____

Have you ever been treated for a skin cancer? □ Yes □ No

Please list any past surgeries: _____

_____

Statesboro Plastic Surgery

Please list any other illness or condition you are currently being treated for by a medical professional: _____

_____

Skin Care Questions
(please fill out to the best of you knowledge)

Do you use any skin care products? □ Yes □ No

What skin care products or cleansing products are you currently using?_____

What technique do you use to cleanse you face and how often? _____

Are you exposed to the sun daily or are you considering spending more time in the sun? □ Yes □ No

Do you use the tanning bed? □Yes □ No If yes, how often and the last time: _____

Have you had recent waxing, surgaring or electrolysis? □ Yes □ No If yes, when and where: _____

Do you form thick or raised scars from cuts or burns? □ Yes □ No

Do you bruse, blister or burn easy? □ Yes □ No If yes, please describe: _____

Do you have hyper pigmentation (darkening of the skin) or hypo pigmentation (lightening of the skin) or maks after physical trama? □ Yes □ No If yes, please describe: _____

Have you used any **Alpha Hydroxy Acid (AHA) or glycolic products** in the past week? □ Yes □ No

Are you using/have you used **Retin-a, Renova, Accutane, Adapalene, Differin Retinol, or Vitamin A derivative** products? □ Yes □ No

Have you ever had any adverse reactions to a skin care treatment? □ Yes □ No If yes, please explain:

_____

Have you ever had any adverse reactions to a skin care products? □ Yes □ No

Rash Irratation Peeling Sun sensitivity Breakouts

If yes, please explain: _____

I understand that charges are payable on the day service is rendered.

Signature: _____ Date: _____

1402 Brampton Ave * Statesboro, GA 30458 * phone 912-681-3330 * fax 912-681-3303

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PAYMENT POLICIES FOR COSMETIC PATIENTS & PROCEDURES

Before we can schedule you for surgery, a 30% deposit must be paid. This deposit is *NON-REFUNDABLE*.

The total cost of the procedure must be paid ***NO LATER THAN 1 WEEK PRIOR TO YOUR SURGERY***. If we have not received your payment by that time, your procedure will be cancelled and your deposit will not be refunded. Payment cannot be made on the day of surgery.

If you are not able to mail us your payment or come to the office, we can take your credit card over the phone. There will be a 3% fee added to the charge for all credit card payments over a $1,000.00.

No Show/Late Cancellation Policy

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis.

A prepayment of $50.00 will be required for all initial Cosmetic Consultation appointments and is Non-refundable if less than 24 hours' notice is given.

A charge of $25.00 will be assessed for each no show or late cancellation for all cosmetic appointments if less than 24 hour notice is given.

By signing below I am agreeing that I have read and understand the above information. I completely understand the payment policies and procedures described to me by the office staff as well as in the document. I have no remaining questions about when payment is due and what types of payments are accepted.

_____ _____

Signature Date

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Picture Release

I am a patient of Statesboro Plastic Surgery. I give my permission to Statesboro Plastic Surgery to utilize my preoperative and postoperative photographs to be shown to future patients, in medical journals, at public presentations, and on the website at www.statesboroplasticsurgery.com for the purpose of education and information.

"I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by the "The American Board of Plastic Surgery, Inc."

I understand that the pictures will be cropped to assure discretion and that any distinguishing marks will be eliminated.

Signature: _____ Date: _____

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