Paragon Plastic Surgery & Med Spa

Skin Care Medical History

Full Name: _____ Date:_____

Address: _____City/State:_____ Zip:_____

*Email address:_____SSN#:_____

Home phone:_____Cell:_____Work:_____

May we contact you at home, on your cell or at work?_____

Emergency Contact: _____ Relation: _____Phone: _____

Date of Birth: _____ Age:_____ Gender:_____

Marital Status:_____ Number of children:_____

Occupation/Employer:_____ Ht:_____ Wt:_____ (lbs)

Race: Caucasian African American Hispanic Asian Other

How did you hear about our office? Friend, TV, Yellow Pages, Newspaper, Magazine, Radio, Other

Reason for your visit?_____

_____

What conditions/problem areas would you like improved:

___Sun damage	___Brown spots/uneven skin	___Dry patches
___Clogged pores	___Acne/pimples	___Unwanted Hair
___Scarring	___Wrinkles	___Dermatitis
___Excessive oiliness	___Blackheads/whiteheads	____Rosacea
___Upper lip lines	___Freckles	

How much time do you spend in the sun? Do you use a tanning bed? _____

Do you wear sunscreen?_____ How often?_____ SPF#/Brand:_____

How would you describe your skin? _____

In the sun, do you: Always burn, Sometimes burn, Sometimes tan, Never burn, Always tan

Any allergies to medications:_____

Any reaction/sensitivity to cosmetics: _____ Allergy to latex/Other:_____

Are you pregnant? _____ Are you breast feeding?_____

Amount of water you drink a day: _____ 8oz glasses.

Please list any other medical conditions?

_____

_____

_____

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Have you ever had the following conditions:

AIDS
Anemia
Arthritis
Asthma
Blood disease
Blood transfusion
Cardiac problems
Chemotherapy
Chronic headaches
Dermatitis
Diabetes
Dizziness
Epilepsy
Eczema
Fainting
Fibromyalgia
Hay fever
Heart disease
Hepatitis
High blood pressure
Infection (active)
Immune disorders
Keloid scars
Kidney disease
Liver disease
Lupus
Melanoma
Nervous disorder
Pacemaker
Psoriasis
Radiation treatment
Respiratory disorder
Rosacea
Skin cancer
Skin disease
Sinus problems
Stomach problems
Stroke
Thyroid problems
Tuberculosis (TB)
Urinary problems
Ulcers
Venereal disease

****Fever Blister(cold sores): < 1/year**
1-3year
>4-1-/year

List all medications you are presently taking:

_____
_____
_____

Check all medications that apply:

bHcg (beta hCG)
Birth Control
Testosterone
Minoxidil
Aldactone
Retin-A Renova
Accutane
NSAIDS / Aspirin
Tetracycline
DHEA
Blood Thinners
Steroids
Thyroid
Chemotherapy
Antidepressants
Vitamin E
Herbals
Acne Medication

Previous Cosmetic Facial Treatments, Surgery, Resurfacing, or Laser Treatments:

___ Acid Peels Date:_____
____Botox Date: _____
____Fillers/Injectables Date: _____
___Tattoo/Perm Makeup Date: _____
___Waxing Date: _____
___Facial Plastic Surgery Date: _____
___Laser Surgery Date: _____
____Microdermabrasion Date: _____

I have answered the above questions truthfully and will notify you of any changes in medications and physical conditions.

Patient Signature:_____ **Date:**_____

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Consent To Treatment, Release of Information, Financial Agreement

CONSENT TO TREATMENT: I understand and acknowledge that Texas Law provides that if any health care worker is exposed to my blood or other bodily fluid, this practice may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including HIV, with or without my consent. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of this surgical practice. I understand the results of tests taken under these circumstances are confidential and do not become part of my medical record. I give my consent to Dr. Mark A. Bishara or his designees to perform or administer all tests and treatment that, in the judgment of Dr. Mark A. Bishara, is advisable during my visit to this surgical practice.

RELEASE OF INFORMATION: I authorize to release/obtain information contained in my financial and medical records, including diagnosis and test results, to/from (a) any of my treating practitioners, (b) my insurance company or health care plan or its representative, or its agents or independent contractors or (c) any other person or entity that is responsible for paying or processing for payment any portion of my medical treatment bill or (d) to any person or entity for the purposes of administration, billing, collecting, and quality assessment and risk management or to any hospital, nursing home, home health agency or to any healthcare institution to which I am transferred. I understand this consent applies to all records created in the course of and relating to my care. I release and agree to hold harmless the surgical practice of Dr. Mark A. Bishara and his representatives and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand this surgical practice cannot be responsible for use or redisclosure of information by third parties.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: In consideration for the medical and surgical services to be or have been rendered to me, I agree to pay for those services. I agree to assign to Dr. Mark Bishara , the benefits under my insurance policies or prepaid health care plan or other reimbursement source. I acknowledge that any balance not covered or paid by such policy or plan is my legal and financial responsibility. I acknowledge that I am aware this practice does not charge interest for late payments. I acknowledge that I am aware that any balance not covered or paid after 120 days, will be turned over to a collection agency and this practice will initiate termination of my patient-physician relationship as described by Texas Law. I acknowledge that any billing-related complaint will be directed to the billing compliance officer. I acknowledge and I am aware that cosmetic surgery procedures are not covered by the benefits under my insurance company and Dr. Mark A. Bishara does not accept insurance reimbursements for cosmetic surgery procedures and all charges related to cosmetic surgery are my own financial responsibility. I acknowledge that I am aware the policy of billing practices and the policy of charity care are both available upon request.

THIS IS A LEGAL CONSENT, FINANCIAL AGREEMENT, AND ASSIGNMENT OF BENEFITS FORM. PLEASE READ IT CAREFULLY AND BE SURE YOUR QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING.

Printed Name: _____ Date:_____

Signature: _____

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PHOTOGRAPHIC CONSENT

Full Name(Print): _____ Date:_____

I, hereby authorize and consent that any and all photographs, images, or videos taken by Dr. Mark A. Bishara at Bishara Cosmetic Surgery Center & The Paragon Med Spa of any part of my body, whether originals or reproductions, may be utilized for such purposes as he may desire in connection with his research, writing, professional activities, and may be used, exhibited and published through any medium whatsoever as part of or in connection with his research, writing, and professional activities, even though such use may be for advertising purposes or purposes of trade. This consent is not retractable, either by oral or written means.

I certify that I have read and understand the aforementioned and sign my name below giving authorization and consent to the foregoing and any photographs, image, or videos taken for future surgeries.

Patient Signature: _____ Date: _____

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Information Request Form -- Cosmetic Surgery & Spa Services

Patient Name:_____ Date:_____

Please let us know if you would like to receive additional information regarding any of the following Cosmetic Surgery and Aesthetic Services that we offer.

Skin Care, Laser Treatments and Non-surgical Aesthetics:

___Skin Care Products for Acne Control
___Skin Care Programs for Sun Damage and Wrinkles
___Skin Care Programs for Blotchy skin
___Chemical Peels for Facial Skin Improvement
___Botox /Filler Treatments for Facial Lines and Wrinkles
___Laser Treatment for Wrinkles
___Laser Treatment for Facial Veins
___Laser Treatment for Hair Reduction
___Laser Treatment for Brown Spots
___Other

Cosmetic Surgery Procedures:

___Facial Cosmetic Surgery (Face lift, eyelid lift, fat transfer, lip augmentation)
___Cosmetic Breast Surgery (Breast augmentation, breast reduction, breast lift, male gynecomastia)
___Body Contouring Surgery (Abdominoplasty, laser liposuction--Lipotherme, liposuction)
___Post Bariatric Surgery (Body lift, arm lift, thigh lift, panniculectomy, removal of skin folds)
___Hair Restoration Surgery / Hair Transplant Surgery (Men and Women)
Hand Rejuvenation

___Other

Thank you. A staff member will contact you soon to offer further assistance.

Bishara Cosmetic Surgery & Hair Restoration

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Acknowledgement of Receipt of Notice of Privacy Practices

Health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice maybe changed at any time. I may obtain a revised copy of the notice by requesting one at this office.

Do you have any restrictions as to how we contact you?_____

Special Instructions:_____

_____

Patient Name(Print)*:_____

Signature: _____ Date:_____

*** If signed by a personal representative, please state your authority to act for**

_____**(Name)**_____

THIS SPACE TO BE USED BY PRACTICE ONLY

Patient Acknowledged Notice of Privacy Practices on Form Provided and Returned Signed Copy.

Accepted _____Denied_____

If Refuse to Sign, Document Reason in Chart: _____

Note: Cannot refuse to see patient if patient refused to sign Acknowledgement

Signed Acknowledgement _____

Accepted _____ Denied _____

Name of Employee Documenting _____

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Fitzpatrick Skin Type Worksheet

Patient Name:_____**Date:**_____

	0	1	2	3	4	Score
What is the color of your eyes?	Light blue, Grey, or Green	Blue, Grey or Green	Blue	Dark Brown	Brownish Black	
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut, Dark Blonde	Dark Brown	Black	
What is the color of your skin (unexposed)	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown	
Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None	
What happens when you stay in the sun too long?	Painful, redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had a burn	
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turns dark brown quickly	
Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always	
How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem	
When did you last expose yourself to sun or tanning beds?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago	
Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always	

Fitzpatrick Skin Type: I(0-7) II(8-16) III(17-25) IV(26-30) V-VI(over 30) TOTAL:____

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