Welcome to Body Aesthetic Plastic Surgery, the office of Dr. C.B. Boswell

Your appointment is scheduled ______________________________

Please print and complete all pages prior to your visit and bring them with you. Please also bring your driver's license or photo ID and arrive 15 minutes early. If you are unable to complete the paperwork in advance, please arrive 30 minutes early to complete it in the office. We pride ourselves in being on time for our appointments. **If you are late, we may ask that you reschedule for another time.**

Please expect to spend at least an hour at our office. Our consultations are designed to provide you with one-on-one time to meet Dr. Boswell and talk about what your needs are. There is a fee of $99.00 to reserve a consultation with Dr. Boswell, payable when booking the appointment. You may apply this fee toward the cost of your surgery or injectables within one year of consultation. This fee does not apply towards the cost of skin care products or skin care services. If you miss your appointment or cancel less than 24 hours in advance you will forfeit the consult fee and be required to pay an additional $99.00 to reserve an appointment. We do not accept any medical insurances.

Please do not hesitate to call our office at 314.628.8200 if you have any questions or if we may be of assistance to you. Our goal is to provide you with exemplary service and the best possible medical care. Again, thank you for calling our office; we look forward to meeting you. Please visit our website for more information: at: www.bodyaesthetic.com.

Sincerely,

Dr. C.B. Boswell and the staff of Body Aesthetic Plastic Surgery & Skincare

969 North Mason Road, Suite 170 ▪ St. Louis, Missouri 63141
314-628-8200 phone ▪ 314-628-9504 fax

Financial Payment Policy

Full payment is due at the time of service for all non-surgical procedures/injectables. Your consultation fee of $99.00 will be applied toward the cost of your surgery or injectable(s) within one year of initial consult with the physician.

For all surgical procedures you will be given a fee quote that is valid for 90 days. The fee quote is composed of the surgeon's fee, anesthesia fee, facility fee, nursing fee and follow up office visits related to this procedure. Additional costs related to services from the facility, other physicians (for example: pathology/pathologist services), and additional surgery which may be required would be your responsibility. A nonrefundable surgery scheduling fee is required to schedule surgery and is applied to the balance. The final balance of the fee quote is due two weeks prior to the date of surgery. No personal checks will be accepted three weeks prior to the surgery date.

We accept cash, check, Cashier's check, debit cards and all major credit cards except for Discover. We do accept financing through Care Credit. If you would like additional information on this, please contact the office. Please ensure that you have payment with you at the time of your office visit. If you do not have a form of payment on your visit, we would be happy to reschedule your appointment.

Insurance

Body Aesthetic Plastic Surgery is not contracted with any insurance companies; however, the practice will see patients that would typically be covered by insurance. We do charge $75.00 for each visit and the payment is due at the time of the appointment. We will not submit to insurance.

Billing Questions

Our practice firmly believes that a good doctor-patient relationship is based upon understanding and good communication. We will make every effort to clarify any misunderstandings you have concerning your balance and resolve your financial questions and concerns. Please notify the office immediately if you have any questions or concerns.

Thank you for choosing Body Aesthetic Plastic Surgery and Skin Care Center.

_______________   ____

Date   *Patient's Signature*

PATIENT REGISTRATION FOR BODYAESTHETIC PLASTIC SURGERY & SKINCARE CENTER

PLEASE PRINT

PATIENT'S FULL NAME (first, middle initial, last)		DATE OF BIRTH	Last 4 digits of SSN
HOME STREET ADDRESS	HOME CITY & STATE		HOME ZIP CODE
MOBILE PHONE #	HOME PHONE #		MARITAL STATUS
E-MAIL ADDRESS			RACE
PATIENT'S EMPLOYER	OCCUPATION ☐ FULL TIME ☐ PART TIME		BUSINESS PHONE #

HOW WOULD YOU PREFER CONTACT/REMINDER CALLS/TEXT FROM THE OFFICE:
☐ HOME ☐ MOBILE ☐ EMAIL

MAY WE ADD YOUR EMAIL TO OUR MONTHLY UPDATES/SPECIALS? Yes ☐ No ☐

SPOUSE OR PARENT'S NAME (IF APPLICABLE)	SPOUSE/PARENT'S EMPLOYER

PERSON RESPONSIBLE FOR PAYMENT (if it is not the patient)	RELATIONSHIP	PHONE NUMBER
ADDRESS (street, city, state, zip code)		

EMERGENCY CONTACT ☐ Check if same as above	RELATIONSHIP	PHONE NUMBER

REFERRING PHYSICIAN: ______________________________ Phone #________________

PRIMARY CARE PHYSICIAN: ______________________________ Phone #________________
(If different from referring physician)

PHARMACY NAME: ______________________________ Phone #________________

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S) AND MEDICATION COVERAGE CARD(S). WE REQUIRE A COPY OF CARDS IN THE CASE OF POSSIBLE PRESCRIPTIONS THAT MAY BE PRESCRIBED. OFTEN PRIOR AUTHORIZATION IS REQUIRED.

Signature______________________________ Date________________

BODYAESTHETIC PLASTIC SURGERY

(314) 628-8200

Health Information as of _______________ (enter today's date)

Patient Name:			
DOB	Age	Marital Status	Weight _________ lbs
What surgery are you considering?			Height ft in

DO YOU NOW OR HAVE YOU EVER HAD.......... (You must circle an answer for each individual item)

Item		
Heart Trouble	Yes	No
Heart Attack	Yes	No
Heart Pain	Yes	No
Palpitation or Irregular Pulse	Yes	No
Extra Heart Beats	Yes	No
Stroke	Yes	No
Hypertension	Yes	No
Blood Pressure Abnormalities	Yes	No
Abnormal EKG	Yes	No
Rheumatic Fever	Yes	No
Dropsy or Heart Failure	Yes	No
Digitalis Treatment	Yes	No
Shortness of Breath	Yes	No
Chest Pain	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Deep vein thrombosis or blood clots	Yes	No
Pneumonia	Yes	No
Tuberculosis	Yes	No
Smokers Cough	Yes	No
Emphysema	Yes	No
Coughing or Spitting of Blood	Yes	No
Hay Fever	Yes	No
Major Allergies	Yes	No
Palsy or Paralysis	Yes	No
Nervous Breakdown	Yes	No
Nervous Disorder	Yes	No
Insomnia	Yes	No
Drug Habit	Yes	No
Self-Destructive Tendencies	Yes	No
Psychiatric Hospitalization or Care	Yes	No
Thyroid Problems	Yes	No
Kidney or Renal Disease	Yes	No
Heart murmur	Yes	No
Piercing other than the ears	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No
Missed or irregular last menstrual period	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No
Have you or a family member had a blood clot?	Yes	No
Have you or a family member ever been diagnosed with a blood clotting disorder?	Yes	No
Have you ever been diagnosed with lupus or any other autoimmune disease?	Yes	No
Glaucoma or Eye Problems	Yes	No
Visual Disturbances	Yes	No
Error in Refraction	Yes	No
Other Eye Problems	Yes	No
Hepatitis	Yes	No
Yellow Jaundice	Yes	No
Gallstones or Gallbladder Trouble	Yes	No
Cirrhosis of the Liver	Yes	No
Alcoholism or Drug Dependency	Yes	No
Esophageal Varices	Yes	No
Frequent Indigestion	Yes	No
Ulcers	Yes	No
Gastritis	Yes	No
Colitis	Yes	No
Problem Constipation	Yes	No
Vomiting Blood	Yes	No
Diarrhea	Yes	No
Tarry or Bloody Bowel Movements	Yes	No
Hemorrhoids	Yes	No
Goiter or Thyroid Disorders	Yes	No
Diabetes	Yes	No
Skin Disorders	Yes	No
Arthritis	Yes	No
Fracture of Neck or Spine	Yes	No
Bleeding Tendency or Disorder	Yes	No
Abnormal Bleeding after Tooth Extraction	Yes	No
Airway Obstruction (Nasal)	Yes	No
Breast Cysts, Tumors, Abscesses	Yes	No
Nipple Discharge (Apart from Normal Lactation)	Yes	No
Kidney Disorder	Yes	No
Blood Transfusion	Yes	No
Seizures or convulsions or fainting spells	Yes	No
Black outs	Yes	No
Dentures, bridges, capped teeth or crowns	Yes	No
Loose teeth	Yes	No
Cosmetic bonding to teeth	Yes	No
Any family members with bleeding problems	Yes	No
Any family members with anesthesia problems	Yes	No
Have you or a family member ever been on blood thinners?	Yes	No
Do you or a family member bruise easily and often?	Yes	No
Have you ever had a miscarriage?	Yes	No

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

____

____

____

2. **Do you have an allergic reaction to any medication? ❒ Yes ❒ No Which?** ____________________

3. Do you react abnormally to any medication? ❒ Yes ❒ No Which? ____________________

4. Do you have a Latex allergy? ☐ Yes ☐ No

5. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?

   ❒ Yes ❒ No ____________________

   ** History of Postoperative nausea and/or vomiting ❒ Yes ❒ No ____________________

6. Have you or a member of your family had a MRSA (antibiotic-resistant staph) infection? ❒ Yes ❒ No If so, who and when?

   ____

7. Have you ever been on cortisone or steroid treatment? ❒ Yes ❒ No When? ____________________

8. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

   ❒ Yes ❒ No If so, how much? ____________________

9. Have you ever smoked? Or used any nicotine type products? ❒ Yes ❒ No If so, how much? ____________

   For how long?____________ If you quit smoking, when did you quit? ____________

   *****most surgical procedures will require smoking/nicotine cessation for 4 weeks before and after surgery***

10. Are you pregnant? ❒ Yes ❒ No When was you last normal menstrual period? ____________________

11. How many pregnancies? _____ Births? _____ How many children did you breast feed? _____ For how long?__________

12. When was your last physical exam? ____________ By whom? ____________________

13. When was your last eye examination? ____________ By whom? ____________________

14. When and where was your last chest x-ray? ____________ EKG? ____________________

15. When and where was your last mammogram? ____________________

16. Who is your personal physician, if any? ____________________

17. Have you ever been under psychiatric care? ❒ Yes ❒ No When? ____________Why? ____________

19. Do you wear acrylic nails? ❒ Yes ❒ No Do you have them on currently? ❒ Yes ❒ No

20. Is there anything else you think the doctor should know? ____________________

____

21. How did you hear about us? ______________________________

22. Who may we thank for referring you to us? ______________________________

23. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

SURGICAL OPERATIONS (include where, when and why for each surgery): ______________________________

____

____

____

____

HOSPITALIZATIONS (include where, when and why for each admission): ______________________________

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____

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By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: ______________________________ Date: ______________