PATIENT REGISTRATION FOR BODYAESTHETIC PLASTIC SURGERY & SKINCARE CENTER – **please write clearly**

PLEASE PRINT

PATIENT'S FULL NAME (first, middle initial, last)		DATE OF BIRTH	SSN
HOME STREET ADDRESS	HOME CITY & STATE		HOME ZIP CODE
MOBILE PHONE #	OTHER 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

Patient Name:		**Date:**	
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)

Heart Trouble	Yes	No	Glaucoma or Eye Problems	Yes	No
Heart Attack	Yes	No	Visual Disturbances	Yes	No
Chest Pain	Yes	No	Hepatitis /Jaundice	Yes	No
Palpitation or Irregular Pulse	Yes	No	Gallstones or Gallbladder Trouble	Yes	No
Stroke	Yes	No	Cirrhosis of the Liver	Yes	No
Hypertension	Yes	No	Alcoholism or Drug Dependency	Yes	No
Blood Pressure Abnormalities	Yes	No	Esophageal Varices	Yes	No
Abnormal EKG	Yes	No	Frequent Indigestion	Yes	No
Rheumatic Fever	Yes	No	Ulcers	Yes	No
Heart Failure	Yes	No	Gastritis/ colitis	Yes	No
Digitalis Treatment	Yes	No	Diarrhea/Constipation	Yes	No
Shortness of Breath	Yes	No	Hemorrhoids	Yes	Np
Asthma	Yes	No	Vomiting Blood	Yes	No
Blood Clots or deep vein thrombosis	Yes	No	Tarry or Bloody Bowel Movements	Yes	No
Pneumonia	Yes	No	Goiter or Thyroid Disorders	Yes	No
Tuberculosis	Yes	No	Skin Disorders	Yes	No
Smokers Cough	Yes	No	Arthritis	Yes	No
Emphysema/bronchitis	Yes	No	Fracture of Neck or Spine	Yes	No
Coughing or Spitting of Blood	Yes	No	Bleeding Tendency or Disorder	Yes	No
Major Allergies	Yes	No	Airway Obstruction (Nasal)	Yes	No
Palsy or Paralysis	Yes	No	Breast Cysts, Tumors, Abscesses	Yes	No
Nervous Disorder	Yes	No	Kidney Disorder	Yes	No
Insomnia	Yes	No	Blood Transfusion	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Seizures or convulsions or fainting spells	Yes	No
Thyroid Problems	Yes	No	Dentures, bridges, capped teeth or crowns	Yes	No
Kidney or Renal Disease	Yes	No	Loose teeth	Yes	No
Heart murmur	Yes	No	Any family members with bleeding problems	Yes	No
Piercing other than the ears	Yes	No	Any family members with anesthesia problems	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No	Have you or a family member ever been on blood thinners?	Yes	No
Missed or irregular last menstrual period	Yes	No	Do you or a family member bruise easily and often?	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No	Have you ever had a miscarriage?	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			

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 meds? ☐ 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 mammogram? _____

15. Who is your personal physician, if any? _____

16. Have you ever been under psychiatric care? ❒ Yes ❒ No When? _____Why? _____

17. Is there anything else you think the doctor should know? _____

18. How did you hear about us? _____

19. Who may we thank for referring you to us? _____

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

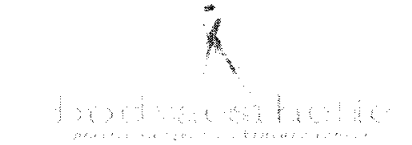
SURGICAL OPERATIONS/HOSPITALIZATIONS _____

_____

_____

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

Signature: _____ Date:_____



Financial Payment Policy

Full payment is due at the time of service for all non-surgical procedures/injectables. Your consultation fee of $125.00 will be applied toward the cost of your surgery or injectable(s) within one year of initial consultation 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 for 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*