Cosmetic Client Profile
Renaissance Facial Plastic Surgery

By completing this information you will be helping us to correctly evaluate your skin care needs.
All information you provide will be kept in strict confidence.

Name: ______________________________ Age ____ Date of Birth____________________

Contact info: please circle your preferred contact # and/or method and circle if we may leave a message at each.

Address: ______________________________ City ___________ St _____ Zip _________

Phone: (Home) ___________ (l.m.? Y/N) (Cell) _________ (l.m.? Y/N) (Work) _________(l.m.? Y/N)

Email: ______________________________ May we contact you by email? Y / N

How did you hear of us? ____________________ SS# ______________________

Dates of upcoming events? ______________________________

Please list any prior cosmetic procedures (both surgical and non-surgical) and dates:

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Have you ever been treated by a dermatologist? Y/N

If yes, for what condition? ______________________________

Do you wear contact lenses? Y/N

Within the last YEAR have you taken or used the following…

Retin A Y/N **Accutane** Y/N

Which of the following would you like to discuss today or are interested in more information on?
Check all that apply:

_____ Botox Cosmetic
_____ Facial fillers (Juvederm, Radiesse, Restylane)
_____ Facial peel
_____ Erbium Laser peel
_____ Fractional CO_2 laser peel
_____ Laser vein removal (spider veins-face, legs, feet, ankles)
_____ Laser rejuvenation procedures
_____ Brow lift
_____ Neck lift
_____ Face lift
_____ Blepharoplasty (eyelid surgery –lower and/or upper)
_____ Rhinoplasty (nose surgery)

_____ Facial Redness
_____ Brown spots
_____ Sun damage
_____ Broken capillaries
_____ Laser hair reduction
_____ Shaving bumps/ingrown hair
_____ Skin toning or pore size reduction
_____ Fine lines & wrinkles
_____ Rosacea
_____ Jane Iredale Makeup
_____ Obagi Skin care products
_____ Skin care program / evaluation

I am here today because I am most concerned about:

____

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Please check any of the following current or past medical conditions:

_____ Lupus or other auto-immune deficiency
_____ Currently pregnant
_____ Bleeding Abnormalities
_____ Rheumatoid arthritis "Gold" therapy
_____ Use of Accutane in last year
_____ Psoriasis or vitiligo
_____ Use of Tetracycline in last month
_____ Keloid or very thick scarring
_____ Pulmonary embolism/blood clot
_____ Implants (location:_______________)
_____ Coumadin anti/clotting agents
_____ Cystic acne
_____ Herpes simplex or **fever blisters**
_____ Scars that turn white or brown
_____ Dark spots after pregnancy/skin injury
_____ HIV
_____ Hepatitis
_____ Light sensitive epilepsy
_____ Hirsutism
_____ Transplant anti-rejection drugs
_____ Diabetes
_____ Leg ulcer or phlebitis
_____ Polycystic ovarian disease (PCOD)

Please check all that apply:

_____ Waxing/plucking/electrolysis w/in 4 wks
_____ Chemical peels, dermabrasion, laser resurfacing facelift
_____ Tattoos/permanent make-up
_____ Collagen injection (location:_____________)
_____ Spray tan (professional) in last 21 days
_____ Self tan, tanning lotions/sprays, tanning bed, sun exposure in last 14 days

Who can we notify in case of an emergency? Name ________________________________
Phone # ____________________________ Relationship ____________________________

I, the undersigned, consent to treatment necessary for the care of the above named patient. I hereby authorize release of any or all medical records to the referring physicians, my insurance carriers, or those involved in payment of my account. I further acknowledge full financial responsibility for any services rendered and understand that payment of charges incurred in the office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to S. Kinney Copeland, M.D., George H. Godwin, III, M.D., and/or Benjamin W. Light, M.D.. In the event an account is not paid within 90 days, the undersigned agrees to pay all costs of collection including attorneys' fees and hereby waives all rights of exemption under the Constitution of the State of Alabama.

Consent Section
I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing. I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the request form available from the office manager. I further understand that the practice is not required to accept my restriction request. I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to the practice. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

Who can we disclose your medical information to?
On the lines below list the names of individuals that are allowed to know your medical information. Be specific.

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____________________________ ____________________________
Patient signature date revised 06/10