THE CENTER
for Plastic Surgery & Skin Care
231.929.7700

DATE

CLIENT INFORMATION

First Name, Middle Initial

Last Name

Home Phone Number

Street Address

City/State/Zip

Work Phone Number

Mailing Address, if different from Street Address

City/State/Zip

Cell Phone Number

Date of Birth

Male ___ Female ___

Emergency Number

Referred by

Email Address (confidential - not shared)

The office communicates news and important information via email, please provide a current email address. We pledge to respect your privacy and will never abuse the privilege of this personal information.

MEDICAL BACKGROUND

Ethnic Skin Type (please circle one): Caucasian African-American Hispanic Asian Eastern Indian American Indian

Please list any skin conditions (Lupus, Psoriasis, Eczema) you are experiencing: _____

Have you ever taken or are currently taking (circle all that apply): Retin A Accutane Tretinoin Differin (in the last 3 months)

Have you ever used an over-the-counter or prescription bleach cream? Yes No

Do you take Topical or Oral Antibiotics (circle all that apply): Oral Topical What is the name of the Antibiotic? _____

How often do you exercise? _____ How many hours of sleep do you get per night? _____

What is your level of stress? Low 1 2 3 4 5 6 7 8 9 10 High

How many 8 oz. glasses of water do you drink each day? _____

How much caffeine and/alcohol do you consume each day? Caffeine _____ Alcohol _____

Are you pregnant? Yes No Do you smoke? Yes No

Please list all supplements, medications, allergies or recent surgeries: _____

_____

How much UV exposure do you get (sun, tanning beds, commuting in car): _____

CLIENT SELF-ASSESSMENT (Reason for visit)

Do you have any of the following (circle all that apply)? Scars Stretch Marks Hyper Pigmentation

Do you suffer from (circle all that apply)? Acne Blackheads Whiteheads Milla Oiliness Rosacea Dehydration Eczema Cellulite
Vein/Circulation Problems Psoriasis (where on your body: _____) Other: _____

Have you ever received any of the following treatments (circle all that apply)?
Facial Microdermabrasion Laser Surgery Chemical Peels Waxing Lash/Brow Tint Laser Hair Removal Vein Treatments Botox/Filler

When did this (these) procedure(s) take place: _____

Please select the statement that applies to you (circle one): I never tan, always burn. I tan with difficulty, usually burn.
I'm an average tanner, sometimes burn. I easily tan, rarely burn. I never burn.

OVER →

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BILLING AND FINANCIAL POLICY

Thank you for choosing The Center for Plastic Surgery & Skin Care for your skin care needs. This Billing and Financial Policy was developed to help you understand how the billing for your services will be handled. If you have any questions, please consult a staff member.

OUR POLICY

YOUR CONSULTATION

- Your Visia Consult with one of our licensed aestheticians is complimentary. You will receive a quote for any services scheduled beyond this appointment.
- Your consult for laser treatment, neurotoxins and/or dermal fillers is $75.00. This fee will be applied towards initial treatment costs.
- If this consult is not paid in full on your day or service, we will not schedule any future appointments.

COSMETIC PROCEDURES

- Cosmetic procedures are not usually a covered benefit by insurance companies. Therefore, we require that you pay the entire procedure fee the day of service.
- All appointments for ANY injectable filler MUST be pre-paid or paid the day of service.
- NO refunds are given for ANY treatments at The Center for Plastic Surgery & Skin Care.

EVENT PRICING OR PRE-PAYMENTS

- The Center for Plastic Surgery & Skin Care will occasionally hold specials that allow you to make pre-payments to take advantage of reduced pricing.
- NO refunds are given for any pre-paid treatment.
- All pre-payments are reviewed at each appointment to ensure funds are being allocated appropriately.
- All event pricing or pre-payments must be used within one year of payment.

I have read the Billing and Financial Policy for The Center for Plastic Surgery & Skin Care. My signature below attests to the fact that I fully understand the policy and agree.

Patient Signature _____ Date _____