PATIENT INFORMATION

First Name:_____ Last Name:_____ Date of Birth:_____

Social Security #: _____ Sex: F M Marital Status: S M D W

Address: _____

City:_____ State:_____Zip Code:_____

Cell #:_____ Home #:_____ Work #:_____

Email Address:_____ Preferred Contact Method: Cell Email

Employment Status: Employed Retired Student Homemaker Employer:_____

GUARANTOR OR RESPONSIBLE PARTY

[_] Same as Patient If not, please indicate relationship to patient:_____

First Name:_____Last Name:_____ Date of Birth:_____

Address: _____

City:_____ State:_____Zip Code:_____

Phone #: _____ Social Security #: _____

Emergency Contact

Name:_____ Phone #: _____

Can Dr. David Brothers and/or staff members discuss matters related to your condition or care with the above named person? YES NO

Referral Source: Whom may we thank for your referral? _____

Reason for Consultation today: _____

May we add you to our monthly email/text list featuring monthly specials and blogs? Yes No

PATIENT MEDICAL HISTORY

Height: _____ Weight: _____

Do you have children? Yes No If yes, how many? _____

Do you drink alcohol? Yes No If yes, please indicate: Daily Weekly

Do you smoke? Yes No If yes, packs per week? _____ Did you ever smoke? Yes No

Do you exercise? Yes No If yes, how often? _____

Do you have a family history of any of the following? *Please Circle if applicable*

Bleeding Disorder Blood Clots Breast Cancer Psychiatric Disorder

If you indicated yes to any of the above, please list family member (s):_____

Have you ever tested positive for HIV or Hepatitis? Yes No Date and Result: _____

Primary Care Physician Name:_____ Phone #:_____

Medications (Include Weight Loss Preparations, Blood Thinners, Vitamins, Aspirin, Anti-inflammatories)

_____

_____

_____

Allergies to Medications: _____

_____

Are you allergic to latex? Yes No

List any surgeries you have had:_____

_____

*****Women Only*****

Have you had a full term pregnancy? Yes No If yes, how many? _____

When was your last mammogram?_____ Results? _____

*If you have not had any of the conditions listed below, please initial here: _____

Place a check mark if you have or have had any of the following conditions listed below:

Anemia		Mitral Valve Prolapse	
Aneurysm		Muscular Dystrophy	
Angina or Chest Pains		Myocardial Infarction	
Anxiety Disorder		Nasal Airway Obstruction	
Arrhythmia		Peripheral Vascular Disease	
Asthma		Pneumonia	
Bleeding Disorder		Polio	
Blood Transfusion		Polyarthritis Nodosa	
Breast Cancer		Prostate Cancer	
Cancer		Psoriasis	
Cold Sores		Pulmonary Disease	
Congestive Heart Failure		Recent Weight Loss	
COPD		Renal Disease	
Deep Vein Thrombosis		Rheumatic Fever	
Depression		Rheumatoid Arthritis	
Diabetes		Sarcoidosis	
Dry Eye Syndrome		Seizure Disorder	
Epilepsy		Skin Cancer	
GI Problems		Stroke	
Glaucoma		Thromboembolism	
Heart Disease		Thyroid Disease	
Heart Murmur		Transient Ischemic Attacks	
Hepatitis		Tubal Pregnancy	
HIV/AIDS		Tuberculosis	
Hypertension		Urinary Tract Infections	
Liver Disease or Jaundice		Varicose Veins	
Lupus		Visual Problems	
Keloid Scars		Pacemaker	
Polycystic Ovary Disease		Acne	
Rosacea		Facial Fillers/Botox/Dysport	
Vitiligo		Implants	
Tattoos		Permanent Makeup	

Separate Corporate Entities:

I understand Plastic Surgery Centre of Atlanta, PC (David B. Brothers, MD, FACS) and Crispin Plastic Surgery (Mark E. Crispin, MD, FACS) are separate Georgia corporations. I understand Alchemy Aesthetics is a subsidiary of Plastic Surgery Centre of Atlanta, PC.

Signature of Patient or Legal Guardian:_____ Date:_____

Receipt of Notice of Privacy Practices Written Acknowledgement Form:

I have received a copy of the Notice of Privacy Practices.

Signature of Patient or Legal Guardian:_____ Date:_____

Payment Agreement:

I have been informed that Dr. Brothers is out-of-network with specific insurances. I understand Plastic Surgery Centre of Atlanta, PC will file my claim with my primary insurance company only. I am responsible for any co-payment after my primary insurance has processed my benefits. I also authorize Plastic Surgery Centre of Atlanta, PC to appeal on my behalf for reimbursement of services rendered.

Signature of Patient or Legal Guardian:_____ Date:_____

Authorization of Release of Information:

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health care practitioners. I authorize and request my insurance company to pay DIRECTLY to the doctor or doctors corporation insurance benefits otherwise payable to me unless I have already paid. I understand my insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all service rendered on my behalf or my dependents.

Signature of Patient or Legal Guardian:_____ Date:_____

Photography Consent:

I hereby authorize Plastic Surgery Centre of Atlanta, PC and David B. Brothers, MD to take confidential photographs of myself in whole or in part for ONLY MY MEDICAL RECORDS OR INSURANCE IF REQUESTED. These photographs will remain property of the above named corporation.

Signature of Patient or Legal Guardian:_____ Date:_____

Other than the service that you are here for today, what additional services would you like to learn about?

Please check all that apply.

Skin care advice		Smile lines		Neck wrinkles	
Skin care products		Brown spots/age spots		Sun damage	
Injectable Treatments		Drooping brow		Eye lift	
Botox/Juvederm		Length of eyelashes		Facial redness	
Facial fine lines/wrinkles		Mole removal		Unwanted hair	
Thin lips		Scar revision		Dark undereye circles	
Forehead wrinkles		Excessive sweating		Eye puffiness	
Frown lines		Arm lift		Stomach	
Crow's feet		Laser resurfacing		Breast reduction	
Liposuction		Thigh lift		Breast lift	
Breast Enhancement		Earlobe repair		Facelift	

Skincare Questionnaire

****FOR AESTHETICIAN CONSULTATIONS ONLY****

Reason for consultation today: _____

Please check any applicable concerns below

Aging Skin		Rough texture		Redness	
Acne		Unwanted hair		Scars	
Wrinkles		Thin lips		Stretch Marks	
Lip lines		Spider veins		Saggy Skin	
Sun damage/brown spots		Frown lines		Unwanted fat	
Enlarged Pores		Rosacea		Sensitive Skin	
Oily Skin		Dry Skin		Other	

Please describe your diet:_____

Do you tan or use tanning beds/self tanner? Yes No If so, when was your last exposure?_____

Do you use sunscreen daily? Yes No If yes, which product are you using? _____

After a cut, does a brown mark remain after it's healed? Yes No

Please list your current skin care regimen: _____

_____

Which of the following do you consider to be your skin type? (please check)

I: Highly sensitive skin, always burns, never tans.	
II: Very sun sensitive skin, burns easily, tans minimally.	
III: Sun sensitive skin, sometimes burns, slowly tans to light brown.	
IV: Minimally sun sensitive skin, burns minimally, always tans to moderate brown	
V: Sun insensitive skin, rarely burns, tans well.	
VI: Sun insensitive, never burns, deeply pigmented.	