EpiCentre℠

PATIENT INFORMATION

NAME _____ BIRTHDATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ BUSINESS PHONE _____

MOBILE PHONE _____ EMAIL _____

EMERGENCY CONTACT _____ EMERGENCY # _____

Is there a # a message can be left regarding treatment? _____

Would you like to receive emails regarding discounts/specials? Yes / No

How did you hear about us?

- ☐ referral from a friend :_____
- ☐ A referral from a Doctor/employee: _____
- ☐ The Internet: _____
- ☐ One of our brochures: _____
- ☐ Facebook: _____

Have you ever seen one of our Plastic Surgeons at DPSI? Yes / No
Which Dallas Plastic Surgery Physician have you seen? _____

Do you use Retin-A? _____ If yes how often? _____

Do you use any products that contain alpha-hydroxy acids? _____

Allergies to Medications? _____

RESPONSIBLE PARTY: (IF A MINOR)

Name _____ Relationship to Patient _____

Address _____

City/State/Zip _____ Phone _____

We Accept MasterCard, Amex, Visa, Discover, Check, Cash - Due at Service

CANCELLATION POLICY:
Due to scheduling considerations,
we request a 24 hour notice for cancellations.

EpiCentre Dallas | 9101 N. Central Expressway, Suite 500 | Dallas, TX 75231 | 214-887-1577
EpiCentre Plano | 5425 W. Spring Creek, Suite 105 | Plano, TX 75024 | 469-229-0598

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PATIENT EVALUATION/CHECKLIST

Name _____ Date _____

Birthdate _____ Age _____ Male / Female HT _____ WT _____ Marital Status _____

Allergies to Medications? _____

Cosmetics _____

History of Herpes/Fever Blister/Shingles _____ Date of Last Outbreak _____
With + hx. of herpes – Start pt. on Valtrex 500mg. BID 2 days pre & 3 days post tx.
Rx Written/Called in to _____ Date _____ Pharmacy # _____

Skin Type:			
	I	White	always burn, never tan
	II	White	often burn, difficult tan
	III	White	sometimes burn, often tan
	IV	Olive/Lt. Brown	rarely burn, easily tan
	V	Brown	rarely burn, always tan
	VI	Black	never burn, always tan

Circle All Nationalities Associated with your Genetic Makeup:

White	Asian	Hispanic	Mediterranean	Middle Eastern		Afro American
Indian	Irish	English	German	Greek	Italian	Spanish/Portuguese

Skin Type:			
	Oily vs. Dry	Sensitive vs. Resistant	Pigmented vs. Non-pigmented
	Rosacea	Wrinkled vs. Tight	Acne Prone

What cosmetic goals do you wish to attain _____

What areas are you interested in treating? _____

Sun Exposure?	☐ Frequent	☐ Moderate	☐ Minimal	☐ Tanning Beds
Do you use a sunscreen?		☐ Daily	☐ Occasionally	☐ Only for outdoor use
	☐ Face	☐ Body	☐ SPF _____	Brand _____

Have you ever had permanent makeup tattooing? Yes / No / N/A If so, when? _____

Circle If Applies To You:

Are you lactating/ pregnant or attempting to become pregnant?	Yes / No
Have you ever had a pregnancy mask/melasma?	Yes / No
Are you on Birth Control Pills / Patch / HRT?	Yes / No
Perimenopausal~Menopausal~Postmenopausal~Hysterectomy	Yes / No
	Year_____

Do you smoke or have you ever? Yes / No Years _____ When did you quit? _____

Do you have a metal stent or implant in your face? Yes / No

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Have you had the Following Cosmetic Procedures on the Brow or Lower Face Areas:

Facial Tightening Treatment within the last year?	Yes / No	Date_____
Injectable Filler?	Yes / No	Date_____
Botox/Dysport?	Yes / No	Date_____
Ablative Skin Resurfacing?	Yes / No	Date_____
Dermabrasion or Deep Chemical Peels?	Yes / No	Date_____
Facelift or Blepharoplasty	Yes / No	Date_____

Medications currently using?

☐ Retin-A ☐ Glycolic/Lactic Acids ☐ Photosensitivity Medications

☐ Topical Cortisone/Antibiotics ☐ Skin bleaching agents

☐ Aspirin-NSAIDS Last dose _____

☐ Anticoagulants/Antiplatelet Last dose _____

☐ Accutane (within last 6 months?) If so, when? _____

List All Medication Currently Taking Including Over the Counter Vitamins/Supplements.
Include Dose/Frequency/When Started and Last Dose taken: _____
_____
_____
_____

Do you have a history of the following: **may alter wound healing*

☐ Vitiligo	☐ *Bleeding disorder
☐ High blood pressure	☐ *Bruise easily
☐ Asthma	☐ Fainting/ Dizzy Spells
☐ Hives	☐ Epilepsy/Seizures
☐ Hepatitis	☐ Chicken Pox/Shingles
☐ Heart or Lung disease	☐ Arthritis ____Gold Therapy for Arthritis?
☐ *Diabetes	☐ Dark spots after pregnancy, skin injury, or surgery
☐ Migraine headaches	☐ Do your scars turn brown before they fade
☐ HIV /AIDS	☐ Do your scars turn permanently white
☐ Hives	☐ Eczema/Skin Diseases/Keloid Scaring
☐ Alopecia/Hair Loss	☐ *Hypothyroidism/Hashimotos
☐ *Anorexia	☐ Hyperthyroidism
☐ Cancer	☐ Fibromyalgia
☐ Disease of Nerve/ Muscles	☐ *Autoimmune Disorder
☐ Pacemaker	(Lupus, Rheumatoid Arthritis)

Any additional information or medical conditions that you would consider pertinent? Yes / No
Please specify _____

Dermatologist: _____ Last Visit/Reason _____
Due to the marked increase in skin cancers over the past decade, it is the recommendation that every patient obtain a yearly skin check with a board certified dermatologist. We will be happy to refer you. This office will not treat suspicious lesions without a signed medical release from your dermatologist. _____ Patient Initials

Patient Signature _____ Date _____

Annual Review: Date: _____ Initial _____

Annual Review: Date _____ Initial _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge and agree that I have been provided a copy of EpiCentre, PLLC's Notice of Privacy Practices that describes how my protected health information must be protected and my rights to access and control such information. I acknowledge and agree that I have reviewed the Notice of Privacy Practices in its entirety and been given the opportunity to ask any questions regarding the use or disclosure of my protected health information and my associated rights. I acknowledge and agree that I have had all my questions answered to my satisfaction.

PATIENT SIGNATURE _____ DATE _____
(OR PERSONAL REPRESENTATIVE)

PRINTED NAME _____

PERSONAL REPRESENTATIVE'S AUTHORITY _____
(IF APPLICABLE)

FOR OFFICE USE ONLY
EPICENTRE, PLLC WILL MAKE A GOOD FAITH EFFORT TO OBTAIN A WRITTEN ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES PROVIDED TO EACH PATIENT. IF A PATIENT IS UNWILLING OR UNABLE TO SIGN THIS ACKNOWLEDGMENT, THE GOOD FAITH EFFORTS TO OBTAIN SUCH ACKNOWLEDGMENT AND REASON WHY THE ACKNOWLEDGMENT WAS NOT OBTAINED MUST BE DOCUMENTED.
REASON: