



PATIENT INFORMATION

DATE: _____

NAME _____ AGE _____ BIRTH DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ BUSINESS PHONE _____

MOBILE PHONE _____ EMAIL _____

PHARMACY _____ PHARMACY # _____

EMERGENCY CONTACT _____ EMERGENCY # _____

Is there a number 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: _____
- Internet/Website/Social Media: _____
- Other: _____

Have you ever seen one of our Plastic Surgeons at DPSI? Yes No

Which Dallas Plastic Surgery Physician have you seen? _____

RESPONSIBLE PARTY: (IF A MINOR)

Name _____ Relationship to Patient _____

Address _____

City/State/Zip _____ Phone _____

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

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

EPICENTRE SKIN CARE & LASER CENTER

9101 N. Central Expressway, Suite 500, Dallas, TX 75231 | 214-887-1577 | epicentreskincares.com

Patient Name _____ Date _____

DOB _____ Gender _____

Check all nationalities associated with your genetic makeup:

- | | | | | | |
|------------------------------------|--|---|--|---------------------------------|----------------------------------|
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Native American | <input type="checkbox"/> German | <input type="checkbox"/> Italian |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> African American | <input type="checkbox"/> Irish | <input type="checkbox"/> Greek | <input type="checkbox"/> Spanish |

Allergies

Medication _____ Type of Reaction _____

Food _____ Lidocaine _____ Seasonal _____

What brings you in today?

- | | | |
|--|---|--|
| <input type="checkbox"/> Fine lines/wrinkles, wrinkles with movement | <input type="checkbox"/> Skin dullness | <input type="checkbox"/> Unwanted body fat |
| <input type="checkbox"/> Deep folds around nose/mouth | <input type="checkbox"/> Volume loss | <input type="checkbox"/> Excessive/unwanted perspiration |
| <input type="checkbox"/> Thinning lips | <input type="checkbox"/> Enlarged pores/acne scars/scars | <input type="checkbox"/> Cellulite/dimpling |
| <input type="checkbox"/> Sagging skin/tissue (face/body) | <input type="checkbox"/> Skin discolorations (Hypo/hyperpigment, redness) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Acne/Rosacea | <input type="checkbox"/> Rough skin texture/dryness | |

Are there any other areas of concern? _____

Any history of adverse reaction to treatments?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Excessive swelling/Angioedema post tx | <input type="checkbox"/> Fat growth after CoolSculpting | <input type="checkbox"/> Prolonged pain | <input type="checkbox"/> Cold sore eruption |
| <input type="checkbox"/> Headache post Botox | <input type="checkbox"/> Post inflammatory hyperpigmentation | <input type="checkbox"/> Stress Incontinence | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Loss of pigment | <input type="checkbox"/> Prolonged bruising/bleeding | <input type="checkbox"/> Vaginal dryness | |
| <input type="checkbox"/> Lidocaine sensitivity | <input type="checkbox"/> Prolonged healing/recovery | <input type="checkbox"/> Vascular occlusions | |

Medical History

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Cold sores/HSV | <input type="checkbox"/> GI disorders | <input type="checkbox"/> Metal implants/Stent/Pacemaker/
Defibrillator | <input type="checkbox"/> Menses: _____ |
| <input type="checkbox"/> Acne/rosacea | <input type="checkbox"/> H/O chicken pox/shingles | <input type="checkbox"/> Migraines | <input type="checkbox"/> Pregnant or trying |
| <input type="checkbox"/> Alopecia/hair loss | <input type="checkbox"/> Heart disease | <input type="checkbox"/> NM/motor neuron disorders/stroke | <input type="checkbox"/> Lactating |
| <input type="checkbox"/> Atopic dermatitis | <input type="checkbox"/> Hernias | <input type="checkbox"/> Bells Palsey/Guillain Barre | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Autoimmune disorders: _____ | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Scars (keloid/surgical/traumatic) | |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> HIV/MRSA/Tb//G+ | <input type="checkbox"/> Seizure/Vertigo | |
| <input type="checkbox"/> Cancer: Type: _____ | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin cancer: Type _____ | |
| Date: _____ Chemo/Radiation | <input type="checkbox"/> Hypo/hyperthyroidism | Location: _____ Date: _____ | |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Liver/kidney disease | <input type="checkbox"/> Skin moles/lesions | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease (COPD/Asthma) | <input type="checkbox"/> Sleep apnea/CPAP | |
| <input type="checkbox"/> Eczema/psoriasis | <input type="checkbox"/> Melasma/Pregnancy mask | | |



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:



RETURN POLICY

Absolutely NO refunds on services, packages or products.

All pre-paid services and packages must be used within one year from the date of purchase.

Product returns or exchanges must be within 30 days from date of purchase and must be unopened with your receipt. A credit will be issued to be used within EpiCentre.

NO REFUNDS!

Print Name _____

Signature _____ **Date** _____



CANCELLATION POLICY

Your appointments are very important to the team members of EpiCentre and these times are reserved especially for you. We understand that sometimes schedule adjustments are necessary; therefore, we respectfully request at least 24 hour notice for cancellations.

STRICT AND ENFORCED 24 HOUR CANCELLATION POLICY!

Please understand that when you forget or cancel your appointment without giving enough notice, we miss the opportunity to fill that appointment time and patients on our waiting list miss the opportunity to receive services. Our appointments are confirmed 48 hours in advance because we know how easy it is to forget an appointment you booked months ago. Since the services are reserved for you personally, a Cancellation Fee will apply.

1. Less than 24 hour notice will result in a charge equal to 50% of the reserved service amount.
2. "NO SHOWS" will be charged 100% of the reserved service amount. If you prepaid for a service or package, that service will be taken out of your package as if it were used at that particular time.
3. Appointments made within the 24 hour period and need to cancel, the patient must cancel within 4 hours of appointment time or will result in a charge equal to 50% of the reserved service amount.
4. Please understand late arrivals will not receive an extension of scheduled services in order to prevent inconvenience to the next patient scheduled and the same treatment price will apply.
5. Any service requiring a 2 hour or more appointment time, will require a 50% deposit to hold that particular appointment.

Our Cancellation Policy allows us the time to inform our standby patients of any availability, as well as keeping our EpiCentre team member's schedules full, thus better serving everyone. EpiCentre policies are presented and provided in the best quality and tradition of excellent service for our established and future patients. Thank you for viewing and supporting our policies criteria.

Print Name _____

Signature _____ **Date** _____

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PHOTO CONSENT

CONSENT FOR TAKING AND USE OF PHOTOGRAPHS, VIDEOTAPE, AND COMPUTER IMAGES

Requested by EpiCentre Skin Care & Laser Center/Dallas Plastic Surgery Institute

Patient Name (*please print*) _____ DOB _____

I certify that I am the Patient or Legal Guardian of the above named patient, and hereby consent that photographs, videotapes, and/or computer imaging may be taken of the above named patient or parts of such patient's body under the following conditions and used for the following reasons:

1. The photographs, videotape, and/or computer imaging may be taken at the consent of such patient's physician/EpiCentre and shall be taken by the physician/EpiCentre or photographer approved by EpiCentre/physician.
2. I authorize EpiCentre/physician to use my photographs, videotapes, and/or computer images for the following educational and/or scientific purposes.
 - Lectures and presentations for an audience of medical professionals or for the general public
 - Medical, surgical, and scientific journal articles or books
 - Selected newspaper and magazine articles, as well as television programs
 - Patient education materials for EpiCentre/physician's office use
 - Patient/physician/EpiCentre education through Internet use
3. I understand that all photographs, videotapes, and/or computer imaging viewed, whether of the patient or other individuals, are demonstrative in purpose and are only a representation of the possible result that could be achieved through the proposed surgery. I further understand that imaging is used as an educational tool to benefit the patient and does not guarantee any result, since plastic surgery is both an art and a science.
4. I understand that the patient will not be identified by name, but that such photographs, videotapes, or computer images may reveal my identity. I accept this loss of anonymity.
5. This authorization is granted in furtherance of medical education, knowledge, research or the general public welfare, and as a voluntary contribution. I/we hereby waive all rights I/we might have to such photographs, videotapes, and/or computer imaging, and do hereby release, discharge and save harmless The Dallas Plastic Surgery Institute and its employees and agents from all claims and liabilities in law and in equity arising from such use.

Patient/Guardian Signature _____ Date _____

Relationship to patient: _____

Witness _____ Date _____

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