EpiCentre
Skin Care & Laser Center
Directed by Dallas Plastic Surgery Institute

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? o Yes o No

How did you hear about us?

- o referral from a friend : _____
- o A referral from a Doctor/employee:_____
- o Internet/Website/Social Media: _____
- o Other:_____

Have you ever seen one of our Plastic Surgeons at DPSI? o Yes o 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 | epicentreskincare.com

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PATIENT MEDICAL HISTORY

Patient Name _____ Date _____

DOB_____ Gender _____

Check all nationalities associated with your genetic makeup:

☐ Caucasian ☐ Hispanic ☐ Middle Eastern ☐ Native American ☐ German ☐ Italian
☐ Asian ☐ Mediterranean ☐ African American ☐ Irish ☐ Greek ☐ Spanish

Allergies

☐ Medication _____ Type of Reaction _____

☐ Food _____ ☐ Lidocaine _____ ☐ Seasonal _____

What brings you in today?

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

Are there any other areas of concern? _____

_____

_____

Any history of adverse reaction to treatments?

☐ Excessive swelling/Angioedema post tx
☐ Headache post Botox
☐ Loss of pigment
☐ Lidocaine sensitivity
☐ Fat growth after CoolSculpting
☐ Post inflammatory hyperpigmentation
☐ Prolonged bruising/bleeding
☐ Prolonged healing/recovery
☐ Prolonged pain
☐ Stress Incontinence
☐ Vaginal dryness
☐ Vascular occlusions
☐ Cold sore eruption
☐ Other _____

Medical History

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

Surgical History

☐ Tummy Tuck ☐ Deep laser resurfacing ☐ Facial implants: Location_____ ☐ Liposuction

☐ Eyelid surgery ☐ Dental implants:_____ ☐ Hernia repair:_____ ☐ Rhinoplasty

☐ Breast aug/reduction /lift ☐ Face lift (upper/lower/neck) ☐ Joint replacement:_____ ☐ Other:_____

Past Aesthetic Procedures

☐ Chemical Peels:_____ ☐ Fat reduction:_____ ☐ Botox:_____ ☐ PDO threads:_____

☐ Skin tightening:_____ ☐ Dermal filler:_____ ☐ Kybella:_____ ☐ Sculptra:_____

☐ Microblading/Perm Makeup :_____ ☐ Other:_____ ☐ Laser Treatments:_____

Social History

Marital Status _____ Use of Retin A/Retinol _____ Sun exposure _____hours per day/wk/mo

Skincare/SPF _____ Tobacco: Cigs/day ___ years___Quit Date _____ Alcohol Intake _____drinks per day/wk/mo

Occupation_____ Illicit Drug Use _____ Exercise type _____hrs/week_____

Medications/Supplements/Vitamins - Please List All

Name	Reason for Taking	Frequency/Dose

Patient Signature Date

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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:

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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 _____

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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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PATIENT CONSENT FOR USE OF CREDIT CARDS

It may become necessary to release your basic health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow EpiCentre's office staff to use and disclose my basic health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

_____I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise.

_____I agree that this non credit card challenge agreement is irrevocable.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

PRINT PATIENT'S NAME

DATE