EpiCentre
Skin Care & Laser Center

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?
☐ Website
☐ Instagram
☐ FaceBook
☐ Google
☐ Referral from a friend _____
☐ Referral from a doctor _____
☐ 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, CareCredit, and PatientFi - Due at Service

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

9101 N. Central Expressway, Suite 500 | Dallas, TX 75231 | 214-887-1577 | Text 469-393-7497 | epicentreskincare.com
Medical Director: Ricardo A. Meade, M.D.

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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

SIGN HERE

Patient Signature Date

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Skin Care & Laser Center

PHOTO CONSENT & NOTICE OF PRIVACY PRACTICES

PHOTO CONSENT

I consent for medical photographs to be taken of me by staff at EpiCentre Skin Care & Laser Center/EpiCentre Park, PLLC/Dallas Plastic Surgery Institute. I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals. By consenting to these medical photographs I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. Refusal to consent to photographs will in no way affect the medical care I will receive. If I wish to withdraw my consent in the future, I may do so with a written request.

I authorize the use of these images:
☐YES ☐NO | For demonstration purpose including an office photo album
☐YES ☐NO | On our website and social media for prospective patients
☐YES ☐NO | In print advertisements and/or professional journals

By signing this form, I confirm that this consent form has been explained to me in terms which I understand.

NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that my protected health information must be protected according to EpiCentre Park, PLLC's Notice of Privacy Practices and that I have the rights to access and control such information. I acknowledge and agree that I have had all my questions regarding the use or disclosure of my protected health information and my associated rights answered to my satisfaction.

While patient anonymity is preserved, there may be incidental identification through the imagery, which I accept.

This consent is granted for medical education, research, or public welfare purposes, and I/we waive any rights to the imagery, releasing EpiCentre Park, PLLC/The Dallas Plastic Surgery Institute and its personnel from any related claims or liabilities.

SIGNATURE

Patient or Patient/Guardian Name *(please print)* _____

Patient or Patient/Guardian Signature_____

Relationship to patient: _____

Witness_____ Date_____

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:

EpiCentre
Skin Care & Laser Center

CANCELLATION & RETURN POLICY

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.

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.

Print Name _____

Signature _____ Date _____