AESTHETICA
COSMETIC SURGERY & LASER CENTER

Phillip J Chang MD

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION

Name: _____
Last First Full Middle Name

_____
Street Address City State Zip Code

Social Security Number: _____ - _____ - _____ Date of Birth (MM/DD/YY): _____ Age: _____

If minor, parent's name:_____ **Parent's Social Security Number**: _____ - _____ - _____

Marital Status (circle one): Single Married Other Gender (circle one): Male Female

Telephone: _____ Work Telephone: _____

E-Mail: _____ May we send you offerings via mail / e-mail? (Circle One) Yes No

Reason for Visit: _____ Primary Referral Source: _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone: _____

MEDICAL HISTORY

Height: _____ Weight: _____ Bra Size (For Breast Consultations Only): _____

Medications that you are allergic to: _____

Are you allergic to Aspirin? (circle one) Yes No Are you allergic to Latex? (circle one) Yes No

Current Medications: Oral, Topical, & Herbal Supplements:

_____

_____

Do you Smoke? (circle one) ☐ Yes No ☐ Do you drink Alcohol? (circle one) ☐ ☐

If so, how much? _____ If so, how much? _____

Do you use Drugs? (circle one) ☐ Yes No ☐ Are you Pregnant / Breast Feeding? (circle one) ☐ ☐

# of Children: _____ # of C-Sections: _____

Previous Surgeries:

Procedure: _____ Year: _____ Procedure: _____ Year: _____

Procedure: _____ Year: _____ Procedure: _____ Year: _____

If you have ever had a problem with Anesthesia, please explain: _____

Please check all of your past and current Medical Conditions:

_____ Anemia or Blood Disorder
_____ Auto-Immune Disorder
_____ Diabetes
_____ Eye Disease/ Dry Eyes
_____ Hepatitis or Liver Disease
_____ Nerve Disorder
_____ Urology Disorder

_____ Arthritis
_____ Cancer
_____ Eating Disorder
_____ Gastroenterology Disorder
_____ High Blood Pressure
_____ Skin Disorder
_____ Other

_____ Asthma or other Lung Disorder
_____ Cold Sores
_____ Epilepsy
_____ Heart Disease
_____ Kidney Disease
_____ Thyroid Disorder

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SERVICES OFFERED

Please check all the procedures about which you would like to receive more information from our staff:

Cosmetic Surgery

_____ Abdominoplasty (Tummy Tuck)
_____ Blepharoplasty
_____ Breast Augmentation/Lift/Reduction
_____ Liposuction
_____ Face/Browlift
_____ Rhinoplasty (Nose Job)
_____ Mommy Makeover
_____ PRP

Non-Surgical Procedures

_____ Diva
_____ Botox
_____ Fillers
_____ Facial Lasers
_____ Laser Hair Removal
_____ PRP
_____ SculpSure
_____ miraDry
_____ Kybella

OFFICE POLICIES

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and other health plans to Dr. Chang. I understand that I am financially responsible for all office and emergency room charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment and assume liability for collection costs. Whether or not my insurance company pays in full, a portion, or no portion of my medical bills, is a matter between me and my insurance carrier. Unless other arrangements have been made, any unpaid balance is due within 30 days of treatment. Payment is accepted in the form of cash, check, credit card, or money order. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for payment. I hereby give my permission to have the appropriate photographs taken for the purpose of completing Dr. Chang's records. These records are confidential and will not be presented without both my and Dr. Chang's written permission.

X _____ _____

Patient Signature (Parent, if minor) **Date**