SANCTUARY

Medical Aesthetic Center ▪ Sanctuary Plastic Surgery

PATIENT INFORMATION

DATE: _____ **E-MAIL:** _____

NAME: _____

ADDRESS: _____ **CELL:** _____

CITY _____ **STATE** _____ **ZIP** _____

DATE OF BIRTH _____ **AGE** _____ **SEX** _____ **MARITAL STATUS** _____

EMPLOYER_____**OCCUPATION**_____

BUSINESS PHONE# _____

EMERGENCY CONTACT _____ **PHONE#** _____

PHYSICIAN/INTERNIST _____

PHARMACY NAME & _____**PHARMACY PHONE#** _____

LIST ALL PREVIOUS SURGERIES/HOSPITALIZATIONS _____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____ **IF YES, LIST** _____

_____

LIST ALL MEDICATIONS AND VITAMINS YOU ARE TAKING (INCLUDING ORAL CONTRACEPTIVES):

MEDICATIONS **DOSAGE** **HOW OFTEN**

_____

_____

_____

HAVE YOU EVER TAKEN ACCUTANE? _____ **IF SO, WHEN DID YOU STOP?** _____

PERSONAL DATA: HEIGHT _____ WEIGHT _____

PREVIOUS MAMMOGRAM (DATE) _____ RESULT _____

HISTORY OF BREAST MASSES _____ PREVIOUS BIOPSY _____

FAMILY HISTORY OF BREAST CANCER (WHO) _____

CHECK ANY OF THE FOLLOWING DISEASES WHICH YOU HAVE OR HAVE HAD:

( ) Excessive Bleeding	( ) Mitral Valve Prolapse	( ) Tuberculosis
( ) Headaches/Migraines	( ) Irregular/Fast Heartbeat	( ) Cancer
( ) Fainting Spells	( ) Rheumatic Fever	( ) Ulcers
( ) Psychiatric Care	( ) Seizure Disorder/Epilepsy	( ) Heart Murmur
( ) Herpes/Cold Sore	( ) Stroke	( ) Pneumonia
( ) Glaucoma	( ) Stomach Problems	( ) Bronchitis
( ) Dry Eye Syndrome	( ) Blood Transfusion Reaction	( ) Emphysema

PT INITIALS _____ **MD INITIALS** _____

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( ) Thyroid Disorder
( ) Liver/Hepatitis/Jaundice
( ) High/Low Blood Pressure
( ) Heart Attack/MI
( ) Circulatory Problems
( ) Prostate Problems
( ) Gout/Arthritis
( ) Pancreas Disorders
( ) Gall Bladder
( ) Asthma
( ) Diabetes
( ) HIV/AIDS
( ) Cataracts

FAMILY HISTORY: List immediate family members either deceased or living with serios illness:

Relationship **Cause of Death** **Age**

_____

_____

_____

SOCIAL HISTORY: Please check and answer all the following questions:

YES **NO**

( ) ( ) Have you or anyone in your family had a problem with Anesthesia?
If yes, please explain: _____

( ) ( ) Do you have skin problems?
If yes, please describe: _____

( ) ( ) Do you smoke?
If yes, how much per day: _____

( ) ( ) Are you a former smoker?
If yes, when did you stop: _____

( ) ( ) Do you drink alcoholic beverages?
If yes, how often: _____

( ) ( ) Do you have vision problems or wear eyeglasses or contact lenses?
If yes, please explain: _____

( ) ( ) Do you wear removable dental appliances/denture?

( ) ( ) Any illegal drug use?

( ) ( ) Do you wear hearing aids?

( ) ( ) Do you have breathing problems?
If yes, please explain: _____

( ) ( ) Do you have a cough?
If yes, describe: ( ) moist ( ) dry

( ) ( ) Are you on a special diet?
If yes, describe: _____

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( ) ( ) Do you have any disease, condition or problem not listed above that you think the doctor should know about? If yes, please explain: _____
_____
_____

( ) ( ) Do you have any reason to believe that you are pregnant? ( ) Yes ( ) No

I have read (or have read to me) the above medical information listing and I hereby certify that I have disclosed all my medical history to the best of my knowledge that the information I have provided above is correct. I understand that I am financially responsible for all charges related to my procedure.

GENERAL DERMATOLOGY

All applicable fees, including, but not limited to, copayments, coinsurance, & deductibles, are payable when services are rendered. I authorized Sanctuary Medical Aesthetic Center to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. All fees are non-negotiable & non-refundable, including those incurred for office visits, procedures, products, or prescription products.

NON-COVERED SERVICES AUTHORIZATION

I understand that services performed today may be denied by my insurance company as medically unnecessary or may be denied as a non-covered benefit. Examples of these services include diagnostic procedures such as blood work & biopsies. I agree to be personally and fully responsible for payment of these services.

AESTHETIC SERVICES/COSMETIC DERMATOLOGY

Sanctuary Medical Center/Sanctuary Plastic Surgery does not accept health insurance, auto insurance, or letters of protection. We do not file insurance claims or complete claim forms. All fees are payable when services are rendered. All fees are non-negotiable & non-refundable, including those incurred for procedures, products, or prescription products.

NO EXCEPTIONS

_____ _____

Patient Signature **Date** **Guarantor or Representative of Minor (Relationship) Date**

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

☐ I acknowledge that I have received the attached Privacy Notice.

☐ I understand that all fees, surgical or non-surgical, are non-negotiable

☐ I understand that to schedule a surgery date, a 20% deposit or $ 500, whichever is greater, must be paid the day that surgery is booked. This deposit is NON-REFUNDABLE,

☐ I consent to receive marketing and promotional messages from Sanctuary Medical Center & Sanctuary Plastic Surgery in the form of SMS and emails.

CONTACT PREFERENCES:

- Leave a message on my voicemail/answering machine at _____
- You may contact me by email at _____
- Do NOT leave a message with anyone other than myself _____

PLEASE TELL US HOW YOU HEARD ABOUT OUR PRACTICE:

- PHYSICIAN _____
- WEBSITE_____
- GOOGLE _____
- YELP _____
- PATIENT REFERRAL _____
- SOCIAL MEDIA _____
- INSTAGRAM _____
- FRIEND _____

I would like information on:

- Liposuction
- Facelift
- Rhinoplasty
- Blepharoplasty (Eyelid Surgery)
- Lasers
- Breast Revisions
- Gynecomastia
- Facials
- Laser Hair Removal
- T-Shape 2
- Skin Care Products
- Fillers
- Botox
- Permanent Make Up

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Patient Acknowledgement

Appointment Cancellation/No Show Policy- Sanctuary Medical Aesthetic Center

Sanctuary Medical Aesthetic Center had instituted an Appointment Cancellation/No show Policy. A cancellation made with less than 24-hour notice significantly limits our ability to make the appointment available for another patient in need.

The following policy for Sanctuary Medical Aesthetic Center states:

1. Please provide our office with 24-hour notice if you need to reschedule your appointment. This will allow us the opportunity to provide care for another patient. A message can always be left with the answering service to avoid a cancellation fee being charged.
2. A "No show", missed appointment, or same day cancellation, without proper 24-hour notification, may be assessed up to a $ 50 fee.
3. This fee is not billable to your insurance.
4. As a courtesy, we make reminder calls for appointments 1-2 days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.
5. Repeated missed appointments may result in termination of the physician/patient relationship.

Consultation Appointment/No Show Policy- Sanctuary Plastic Surgery

Sanctuary Plastic Surgery has instituted a Consultation Appointment/No show Policy. A cancellation made with less than 24-hour notice significantly limits our ability to make the appointment available for another patient in need.

1. Please provide our office with 24-hour notice if you need to reschedule your consultation. This will allow us the opportunity to provide care for another patient.
2. A $ 100 fee will be assessed for not cancelling/rescheduling your consultation appointment within 24 hours of your scheduled appointment.
3. This fee is not billable to your insurance, and it does not apply towards your surgery.
4. As a courtesy, we make reminder calls for appointments 1-2 days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.
5. Repeated missed appointments may result in termination of the physician/patient relationship.

I have read and understand the Appointment Cancellation/No Show Policy and I acknowledge its terms.

PT INITIALS _____ **MD INITIALS _____**