Cosmetic Interest Questionnaire

Please complete the following form and return to the front desk so that we may best serve your needs.

Patient Name: _____ Date: _____

For the following statements, please check off the areas that interest you at this time:

YES ____ NO ____ I would like to be contacted for further information, events and promotions

YES ____ NO ____ I would like to improve the condition and appearance of my skin.

YES ____ NO ____ When looking at my face in the mirror, I believe I look older than my true age.

YES ____ NO ____ I am interested in surgical procedures for body shaping and sculpting.

YES ____ NO ____ I am interested in non-surgical options to correct fine lines & wrinkles.

YES ____ NO ____ I am interested in rejuvenating my eyes.

YES ____ NO ____ I am interested in contouring and re-shaping my nose.

YES ____ NO ____ I am interested in full face rejuvenation.

YES ____ NO ____ I am interested in non-surgical procedures for body shaping and sculpting.

YES ____ NO ____ I would give consent for part of my treatment to be photographed or filmed for social media

How did you hear about our office? (Please check)

□ Internet Search □ Real Self □ News Segment □ Word of Mouth

□ Instagram □ Facebook □ Twitter □ YouTube

□ Staff □ I am a Prior Patient □ Patient Referral _____

□ Dr. Referral_____ □ Magazine _____

□ Hair Salon / Stylist _____ □ Other _____

DANIEL I. SHAPIRO, MD, F.A.C.S.
SHAPIRO AESTHETIC PLASTIC SURGERY AND SKIN KLINIC

PATIENT DATA

Patient Name_____ Date_____

Birthdate _____ Age _____ Marital Status _____

Address _____

City _____ State _____ ZIP _____

E-Mail _____ Male _____ Female _____

Occupation _____

Home Telephone _____

Office Telephone _____

Mobile Telephone _____

Personal Goals

I am here today to discuss: _____

My goals are to improve my appearance by: _____

I would describe the present condition I wish to improve as: _____

Background

I have decided to consult with Dr. Shapiro because: _____

I have consulted with the following physicians, friends or family about my goals: _____

I have the following skin conditions:

___ Hyperpigmentation
___ Melasma
___ Sun damage/brown spots
___ Facial wrinkles
___ Expression lines
___ Acne
___ Facial veins
___ Rosacea
___ Sensitive skin
___ Irregular moles or skin growths
___ Enlarged pores

I currently use the following skin care products: _____

_____

_____

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PATIENT MEDICAL HISTORY

Patient Name_____ Date_____

Whom may we contact with regard to your medical conditions?

Primary Care Physician: _____ Telephone: _____

Address: _____

Whom may we contact in an emergency?

Name: _____ Relationship: _____

Telephone: _____ Address: _____

Pharmacy Information (Required)

Name: _____ Phone Number: _____

Address: _____

Lifestyle and Personal History:

I presently smoke (electronic included)	Yes	No	I have smoked	Yes	No
I presently use tobacco products	Yes	No	I have used tobacco products	Yes	No
I use recreational drugs	Yes	No	I have used recreational drugs	Yes	No

My regular exercise routine (type and frequency): _____

I consume alcoholic beverages (amount and frequency): _____

I take the following vitamins/herbal supplements (type and dosage): _____

_____

Health history:

Height: _____ Weight: _____

I regularly take the following prescription/over-the-counter medications (type and dosage): _____

_____

I presently take the following prescription/over-the-counter medications (type, dosage and purpose): _____

_____

I am allergic to the following medications: _____

I have the following additional allergies: _____

I have had a staph infection in the past: _____ If yes, please explain: _____

I am presently under a doctor's care for the following conditions: _____

I have the following medical conditions: _____

I would describe my present state of health as: _____

I have had the following treatments:

___ Non-cosmetic surgery (list type and date) _____

_____

___ Aesthetic or cosmetic surgery (list type and date) _____

_____

___ Botox® or similar treatment (botulinum type/regions treated/frequency/date of last treatment) _____

_____

___ Injected or implanted fillers (filler type/regions treated/date of last treatment) _____

_____

___ Chemical peel (define the type of peel and concentration) _____

___ Dermabrasion or dermaplaning (date of last treatment) _____

___ Laser resurfacing (date/outcomes) _____

___ Photorejuvenation (date/outcomes) _____

___ Other energy-based treatments (i.e. Thermagge®) (date/outcomes) _____

I attest the above history is completed to the best of my knowledge and understand and accept that my failure to disclose any of the above information can adversely affect a prescribed course of treatment to meet my goals, my safety, or the outcome of any treatment I elect to undergo with Daniel I. Shapiro, MD, or any member of his staff, including the Paradise Valley Skin Klinic.

_____ _____

Patient signature Date

Please check any of the following conditions that you now have (or have ever had):

____ Asthma
____ Hay Fever
____ Allergy Problems
____ Hives
____ Allergy to local anesthetics
____ Allergy to latex
____ Cancer
____ Skin cancer
____ Sun poisoning
____ Cold sores/fever blisters
____ Pacemaker
____ Mitral valve prolapse
____ Artificial heart valve
____ Artificial joints
____ Abnormal chest x-ray

____ High blood pressure
____ Chest pain
____ Heart attack
____ Heart murmur
____ Irregular heartbeat
____ Joint pains/arthritis
____ Thyroid problems
____ Kidney disease
____ Bowel disorder
____ Stomach problems
____ Liver disease
____ Hepatitis
____ Exposure to AIDS
____ Blood clot in leg
____ Blood clot in lung
____ Seizures

____ Nervous disorders
____ Mental Illness
____ Depression
____ Shingles
____ Stroke
____ Faint easily
____ Glaucoma
____ Cataracts
____ Diabetes
____ Positive skin test for tuberculosis
____ Anemia
____ Irregular periods
____ Yeast infection
____ HIV/Positive HIV test
____ Sexually transmitted disease

___ Headaches
___ Sleep disorders
___ Sleep Apnea
___ Vision Trouble
___ Hearing impairment
___ Sinus problems

___ Persistent cough
___ Shortness of breath
___ Bruising easily
___ Frequent nosebleeds
___ Foot or ankle swelling
___ Leg cramps

___ Extreme weight loss/gain
___ Heartburn
___ Difficulty urinating
___ Keloids/excessive scarring
___ Sensitive Skin

My last tetanus shot was: _____

I would describe my present state of health as: _____

Female Patients:

I AM / AM NOT now pregnant I AM / AM Not now nursing

I have given birth to _____ children I have had _____ Cesarean deliveries

I take/use the following contraceptives or hormone replacement therapy _____

My last mammogram was on _____ and was reported to be: _____

I attest the above health history is completed to the best of my knowledge and understand and accept that my failure to disclose any medical condition can adversely affect my safety or the outcome of any treatment I elect to undergo with Daniel I. Shapiro, MD, or any member of his staff, including the Paradise Valley Skin Klinic.

I consent that the above information is not a substitute for diagnostic medical testing that may be required prior to any surgical or other treatment. I consent that the above information is strictly used for screening purposes to determine my overall health.

_____ _____

Patient Signature Date

DANIEL I. SHAPIRO, MD, F.A.C.S.
SHAPIRO AESTHETIC PLASTIC SURGERY AND SKIN KLINIC

PATIENT PRIVACY and CONSENT

FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby consent to the use or disclosure of my protected health information by the practice of Daniel Shapiro, M.D., hereinafter referred to as ("Practice"), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. I understand that payment for such procedures may be requested in advance of any treatment. I understand there are no warrantees, implied or otherwise, to the outcomes any treatment or procedure.

I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Practice is not required to agree to the restrictions that I may request. However, if the Practice agrees to the restrictions that I request, such restriction is binding on the Practice.

I have the right to revoke this consent, at any time, in writing, except to the extent that the Practice has taken action in reliance on this consent.

My "protected health information" means health information and my demographic information collected from me and created or received by: the Practice, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me.

I understand I have a right to review the Practice's *Notice of Privacy Practices*, which has been offered to me by the practice, prior to signing this document. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This *Notice of Privacy Practices* also describes my rights and the practice's duties with respect to my protected health information. The *Notice of Privacy Practices* for the Practice is available at the offices of the Practice: 5410 N. Scottsdale Road Suite F-100 Paradise Valley, Arizona 85253.

Terms of the *Notice of Privacy Practices* may change. If changes are made, I may obtain a revised *Notice of Privacy Practices* by: calling the offices of the practice requesting a revised copy be sent in the mail, or by requesting one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Signature of Practice Representative and Witness