HILL COUNTRY
Cosmetics

Patient Name: _____ Date of Birth: _____ Date: _____

Age: _____ Male ❑ Female ❑ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Drivers License #: _____ Employer: _____

Occupation: _____ Work Phone: (_____)_____

Email Address: _____

BILLING CONTACT

Name: _____ Relationship to Patient: _____

Address: _____ Phone: (_____)_____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Address: _____ Phone: (_____)_____

HOW DID YOU HEAR ABOUT US?

❑ Doctor: _____ ❑ Insurance

❑ Friend ❑ Internet /Website

❑ Ad (*which publication?):* _____ ❑ Radio

COMMUNICATION

Would you like to be included in our email list for specials and events? ❑ Yes ❑ No

PREVIOUS COSMETIC EXPERIENCE

Have you had any previous cosmetic services? ❑ Yes ❑ No

If Yes, which? ❑ Botox / Dysport / Xeomin

❑ Juvederm / Voluma / Restylane / Perlane / Radiesse / Belotero / Artefill / Sculptra

❑ Laser treatment, which:_____

❑ Photofacial / IPL ❑ Radiofrequency ❑ Chemical Peel ❑ Microneedling

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Patient Name: _____ Date of Birth: _____ Date: _____

ACKNOWLEDGEMENTS/CONSENTS *(please initial on the line next to each section after reading)*

_____ **Receipt of Notice of *Privacy Practices***

I, *(print patient or guardian name)*_____, have read a copy of Hill Country Cosmetics' *Notice of Privacy Practices.* (This document is available at our front desk or HillCountryCosmetic.com.)

_____ **Cancellation Policy**

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Hill Country Cosmetics reserves the right to charge the patient a $50 fee if the patient does not cancel the appointment within 24 hours.

_____ **Release of Medical Information**

I **do / do not** *(circle one)* authorize Hill Country Cosmetic and its designated representatives to release medical information to my spouse, parent, or guardian.

_____ **Contact Permission**

In the event that Hill Country Cosmetics needs to contact you (patient) regarding an appointment, medication, or any other reason, it is permissible to *(check all that apply)*:

- ❑ Leave a message on an answering machine.
- ❑ Speak with spouse / significant other. (Name:_____)
- ❑ Speak with other family members.

_____ **Consent to Treatment**

I consent to the performance of those elective procedures, examinations, and the rendering of treatment by the medical provider and their designated office staff as is deemed elective in the medical provider's judgment. The results of cosmetic services are usually dramatic, although the practice of medicine is not an exact science and no guarantees can be or have been made concerning expected results.

_____ **Consent for Photographs**

I consent to photographs being taken of me, or parts of my body showing before and after results of procedure(s) as part of my medical record. I understand that these images will not be published in any way without my written consent.

_____ **Authorization / Assignment / Financial Responsibility**

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of our payment policies. Payment is required for all services at the time they are rendered. Payments for products and services are *non-refundable.*

My signature below indicates that I have read and am in agreement with all statements that I have initialed above.

_____ _____

Signature of Patient (or guardian) Date

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Patient Name: _____ Date of Birth: _____ Date: _____

MAIN REASON(S) FOR TODAY'S VISIT

What are the main reason(s) for today's visit? _____

What are your concerns? lines/wrinkles pigment issues texture tone acne scarring loose skin

product suggestions general consultation rosacea/redness spider veins large pores volume loss

MEDICATION/MEDICAL HISTORY

1. Current Medications *(prescription, non-prescription, herbal, creams, sprays, pills, liquids, drops):*

   1._____ 4._____ 7._____

   2._____ 5._____ 8._____

   3._____ 6._____ 9._____

2. Food & Drug Allergy/Intolerance: D*escribe when/what reaction occurred or (circle):*

   None known eggs milk lidocaine collagen (cow/pig/bird) Citrus Aspirin

   1._____ _____

   2._____ _____

   3._____ _____

3. Your preferred pharmacy and location? _____

4. Hospitalizations / Operations (include dates):

   1._____ 4. _____

   2. _____ 5. _____

   3. _____ 6. _____

5. Other problems? *(please circle any that you have now or have had in the past)*

High blood pressure	Reflux	Thyroid problems	Heart attack
Hiatal hernia	Kidney problems	Stroke	Diabetes
Chronic infections	Glaucoma	Emphysema	Kidney disease
Cataracts	History of asthma	Myasthenia Gravis	Depression
Gout	Liver problems	Bipolar	Arthritis
Cancer of _____	ADD/ADHD	Fibromyalgia	Bleeding problems
Cold Sores/Fever Blisters	Multiple Sclerosis	Osteoporosis/osteopenia	Liver disease

Autoimmune Disorder:_____ Presence of metal implants (pacemaker, Screws, rods, plates)

Other _____