



PATIENT INFORMATION (PLEASE PRINT)

Name: _____ Date of Birth: _____ Sex: Male Female
Social Security #: _____ Marital Status: Single Married Separated Divorced Widowed
Address: _____ City: _____ State/Zip: _____
Home Phone: _____ Cell #: _____ Work #: _____
Employer: _____ Occupation: _____
Email Address: _____ Referred by: _____
Family Physician: _____ Cardiologist: _____

GUARANTOR INFORMATION (IF PATIENT IS A MINOR)

Guarantor Name: _____ Date of Birth: _____ Sex: Male Female
Social Security #: _____ Relation to Patient: Spouse Parent Other(_____)
Home Phone: _____ Cell #: _____ Work #: _____

EMERGENCY CONTACT

Name: _____ Phone #: _____ Relationship: _____

INSURANCE INFORMATION. Primary Insurance: _____ Secondary: _____

ID# _____ GROUP# _____

INSURANCE POLICYHOLDER'S INFORMATION (IF NOT THE PATIENT)

Name: _____ Date of Birth: _____ Sex: Male Female

Social Security #: _____ Relation to Patient: Spouse Parent Other(_____)

PATIENT BILLING NOTICE & RELEASE OF INFORMATION

- I assign benefits and authorize payment from my insurance plan (Medicare/Medicaid/Other) directly to Rau Plastic Surgery for any claim filed on my behalf. I authorize the release of medical records and/or information to my insurance company to assist with payment for services rendered. I authorize the release of medical records to and from Rau Plastic Surgery and other medical providers when necessary for my treatment or my care.
- I accept financial responsibility for all services that I receive and agree to pay for all services that are not paid by insurance benefits, for whatever reason – including, but not limited to deductibles, co-payments, co-insurance, and/or non-covered amounts.
- I understand that if I fail to make timely payment, I may be sent to a collection agency. I agree to pay collection and/or attorney fees if charged. I consent to receive communications regarding my account from any collectors until my account is settled. I will incur NSF fees for returned checks.

Patient Signature (or representative): _____ Date: _____

If Authorized Representative, please list relationship to patient: _____



Skin Care Consultation

Date: _____

Name: _____ DOB: _____

Address: _____

Cell Phone: _____ Email: _____

• I DO NOT wish to be notified of **specials** and **promotions**.

How did you hear about us? _____

The aging process is multifaceted involving structure, volume loss, and skin care. Please complete this analysis so we can find the best treatment options for you individually.

Are you a member of either one of the following rewards programs? (Circle one)

Alle Aspire Rewards

If the answer is no and you receive injectable treatments today we will gladly create an account for you. If you are NOT interested and wish to decline additional discounts on injectable service please initial here _____.

Please fill in the following regarding injections and skin therapy:

	Date of last treatment	Type of product
Botox/Dysport/Xeomin	_____	_____
Filler (Restylane, Juvederm, etc.)	_____	_____
Chemical Peel	_____	_____
Laser/ Light Therapy	_____	_____
Microdermabrasion/ Needling	_____	_____

Are you currently being treated by a dermatologist? Y/N

If yes, what for?

Have you taken Accutane (acne medication) within the last 6 months? Y/N

Have you used a Retinol or Retin-A in the past 5 days? Y/N

Have you ever had a fever blister (cold sore)? Y/N

Do you? (circle all that apply)

Smoke Consume alcohol Exercise Tanning bed Take vitamins Eat well

Are you pregnant or nursing? Y/N



List any current medical problems: _____

Past Surgeries: _____

Have you ever been diagnosed with a connective tissue disease such as Lupus or Scleroderma? (If so treatment with Sculptra Aesthetic is contraindicated) Y / N

List any **allergies** to food or drugs:

What **medications** are you currently taking on a daily basis?
(Please include dose and frequency)

Do you bruise easily? Y/N Does your skin heal quickly? Y/N

Have you or anyone in your immediate family had: (circle)

Skin Cancer Acne Rosacea Allergies

Would you consider your skin to be: (circle one)

Oily T-zone Normal Dry Dehydrated

Have you ever considered your skin to be sensitive? Y/N

How does your skin tan? (circle one)

Burn Burn then tan Usually tan Tan quickly Never burn (brown) Never Burn (black)

What do you use to:

Cleanse your face? _____ Exfoliate (toner)? _____

Moisturizer? _____ Mask or peel? _____

Sunblock? _____ Eye or lip product? _____

Other skincare products? _____

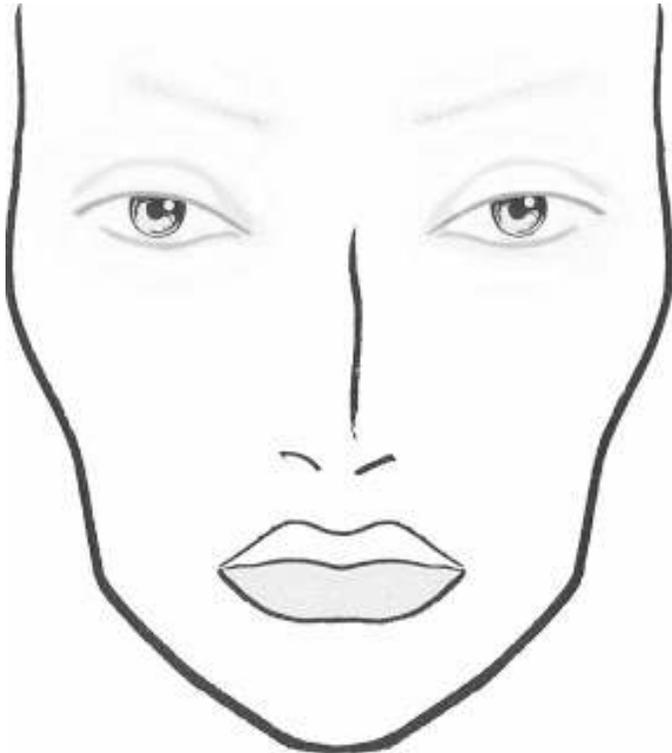
What is your main goal regarding your skin?

MR _____



Injection Treatment Record
(Office use only)

Date _____



Botox/Dysport units: _____

Product Label:

Notes: _____

Katelyn Rau RN