AESTHETICA
COSMETIC SURGERY & LASER CENTER

Phillip J Chang MD

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION

Patient Name: Last Name	First Name	Middle Name	
Street Address	City	State	Zip Code
Social Security Number:	Date of Birth:	Age: 00	

If minor, parent's name: First & Last Name	**Parent's Social Security Number**: 000 - 00 - 0000
Marital Status: Choose an item	Gender: Choose an item
Cell Phone: 000-000-0000	Work Telephone: 000-000-0000
E-Mail: Email Address	May we send you offerings via mail / e-mail? Choose an item
Reason for Visit: What would you like to know more about? Primary Referral Source: How did you hear about us?	

Emergency Contact Information: Name: First & Last Name	Relationship: How do you know one another?	Phone: 000-000-0000

MEDICAL HISTORY

Height: 0'00"	Weight: 000 lbs	Bra Size (For Breast Consultations Only): What is your best guess?
Medications that you are allergic to: Make sure we know you if have any sort of allergies.		

Are you allergic to Aspirin? Choose an item	Are you allergic to Latex? Choose an item
Current Medications: Please list medication(s) and dosage(s). If none, type none. Oral, Topical, & Herbal Supplements: Please list supplement(s) and dosage(s). If none, type none.	
Do you Smoke? Choose an item If so, how much? How many per day? Do you use Drugs? Choose an item	Do you drink Alcohol? Choose an item If so, how much? How much? Are you Pregnant / Breast Feeding? Choose an item
Previous Surgeries: Procedure: Procedure & Year Procedure: Procedure & Year	Procedure: Procedure & Year Procedure: Procedure & Year
If you have ever had a problem with Anesthesia: Choose an item. Explanation, if necessary.	

AESTHETICA
COSMETIC SURGERY & LASER CENTER

Phillip J Chang MD

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

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

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 ____________________________________ Date

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