Premier COSMETIC SURGERY & Medispa

PATIENT INFORMATION

Name: _____

Address: _____

Sex: ❒ **M** ❒ **F** **Age:** _____ **Birth Date:** _____

Height: _____ **Weight:** _____

Social Security Number: _____

Occupation: _____

Hobbies: _____

Marital Status: ❒ Single ❒ Married ❒ Widowed ❒Divorced/Separated

Spouse/Significant Other's Name: _____

Children & Ages:_____

How did you hear about us? _____

Have you been to our website? ❒ **Yes** ❒ **No**

(www.premiersurgeryseattle.com)

CONTACT INFORMATION

Home: _____ **Cell:** _____

Work: _____

Email: _____

Best Time & Place to Reach You: _____

EMERGENCY CONTACT:

Name: _____ **Relationship:** _____

Home: _____ **Cell:** _____

Work: _____

PROCEDURE(S) OF INTEREST

BODY PROCEDURES

- ☐ Arm Lift
- ☐ Breast Augmentation
- ☐ Breast Implant Revision
- ☐ Breast Lift
- ☐ Breast Reduction
- ☐ Body Lift
- ☐ Fat Transfer
- ☐ Thigh/Butt Lift
- ☐ Tummy Tuck
- ☐ Other

LIPOSUCTION

- ☐ Abdomen
- ☐ Arms
- ☐ Back
- ☐ Buttocks
- ☐ Chest (Men)
- ☐ Hips/Flanks
- ☐ Knees
- ☐ Neck
- ☐ Thighs—Inner
- ☐ Thighs—Outer
- ☐ Waist

FACIAL PROCEDURES

- ☐ Brow/Forehead Lift
- ☐ Ear Pinning
- ☐ Earlobe Repair
- ☐ Eyelid Surgery
- ☐ Facelift
- ☐ Neck Lift

MEDISPA

- ☐ Laser Hair Removal
- ☐ Laser Skin Rejuvenation
- ☐ Laser Mole Removal
- ☐ Glycolic Peel
- ☐ Botox
- ☐ Facial Fillers
- ☐ Lip Augmentation

FINANCIAL POLICIES *(for cosmetic surgery patients)*

Financial quotes provided are inclusive of surgeon's fees, implants (when applicable), initial postoperative garments, and all preoperative and postoperative visits. Quotes are estimates only and are subject to change at the doctor's discretion. Facility and anesthesia fees are also estimates only and subject to change. Prescriptions, necessary lab work fees, and additional garments are the patient's responsibility. Any revision procedures are subject to additional facility and anesthesia fees. A 50% deposit is required to reserve a surgery day of which $1000 is non-refundable and non-transferable. A refund equal to the amount deposited minus the $1000 non-refundable/non-transferable deposit will be given if surgery is canceled at least two (2) weeks prior to the scheduled surgery day. A refund equal to 50% of the refundable fees will be given if surgery is canceled 1-2 weeks (8-14 days) prior to the scheduled surgery day. If surgery is canceled within seven (7) days of surgery, no refund will be given. A deposit will hold a date, but not necessarily a surgery time. Surgeon and facility fees must be paid at least ten (10) business days prior to surgery or at the preoperative appointment, whichever comes first. Payments can be made by cash, check, money order, cashier's check, credit card (Visa, MasterCard, or Discover) or through an approved finance company. We do not bill insurance or accept personal checks at this time.

I have read and understand the above financial policies.

Signature: _____ **Date:** _____

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Please check if you have ever had or been treated for the following:
(Use the back of this sheet for any explanations.)

Respiratory	Cardiovascular	Neuro/Muscular
____ Allergies / Hay Fever	____ High Blood Pressure	____ Stroke
____ Asthma / Wheezing	____ Chest Pain	____ Epilepsy
____ Chronic Cough	____ Heart Attack	____ Headaches
____ Coughing Blood	____ Heart Murmur	____ Head Injury
____ Lung Trouble	____ Heart Arrhythmia	____ Numbness in Limb
____ Pneumonia	____ Abnormal Stress Test	____ Excessive Fatigue
____ Shortness of Breath	____ Swelling in Ankles/Feet	____ Cataract / Glaucoma
____ Tightness in Chest	____ Dizziness / Fainting	____ Eye Injury / Disorder
____ Pulmonary Embolism	____ Rheumatic Fever	____ Ringing in Ears
____ Sinus Trouble	____ Scarlet Fever	____ Bone / Joint Problems
____ Snoring		____ Back Problems
____ Sleep Apnea		____ Rheumatism / Arthritis
____ Tuberculosis		____ Gout
Gastrointestinal / Hepatic	**Hematology / Renal / Endocrine**	**Other**
____ Vomiting Blood	____ Anemia	____ HIV / AIDS
____ Change in Bowel Habits	____ Family History of Bleeding Problems	____ Cancer
____ Bleeding	____ Blood Clots	____ Bariatric Patient
____ Indigestion / Acid Reflux	____ Bladder Infection	____ Sexually Transmitted Disease
____ Stomach Ulcers	____ Burning with Urination	____ Excessive Worry or Depression
____ Hepatitis	____ Chills, Fever, or Night Sweats	____ Difficulty Sleeping
____ Liver Disease	____ Diabetes	____ Skin Rash / Disease
____ Jaundice	____ Recent Change in Weight	
____ Loss of Appetite, Nausea	____ Thyroid Trouble	

Allergies & Sensitivities (include foods found in medications such as shellfish, iodine, eggs): _____

_____

Current Medications & Diet Supplements (include vitamins, birth control, hormone replacement therapy, diet pills):

_____

Major Illnesses: _____

List ALL Surgeries: _____

_____

Special Medical Conditions: _____

Please answer the following questions:

Do you smoke? ❒ Yes ❒No How much?_____ How long?_____

Do you drink? ❒ Yes ❒No How often? _____ Last drink? _____

If female, are you pregnant? ❒ Yes ❒No Date of last menstrual period: _____

Have you or a relative ever had a bad reaction to anesthesia? ❒ Yes ❒No

Do you wear contact lenses or glasses? ❒ Yes ❒No

Do you wear dentures? ❒ Yes ❒No

Do you have a history of chemical dependency? ❒ Yes ❒No

Are you under treatment for anxiety or depression? ❒ Yes ❒No

Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

Patient Preop Signature: _____ **Date:** _____