



Carolina Cosmetic Institute



Patient Health History

First Name: _____ Last Name: _____ Middle: _____

Address: _____ City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Which number may we use to leave messages or communicate with you? _____

Social Security Number _____ Date of Birth _____ Occupation _____

Email Address (strictly for CCI promotions/discounts) _____

Reason for your visit today? _____

How did you hear about Carolina Cosmetic Institute? _____

Please list all medications you are currently taking including aspirin, vitamins, herbs and/or herbal tonics.

Medication & Dosage	Reason	Medication & Dosage	Reason

Are you allergic to any medications or non-medical items? Please list below.

Allergy	Reaction	Allergy	Reaction

Do you or have you ever had any of the following conditions or treatments? (Please circle "Yes" or "No")

Acne	Yes	No	Diabetes	Yes	No	Thyroid Problem	Yes	No
Dermatitis	Yes	No	Eczema	Yes	No	High Blood Pressure	Yes	No
Fever Blisters	Yes	No	Skin Cancer	Yes	No	Laser Resurfacing	Yes	No
Hormonal	Yes	No	Cancer	Yes	No	Are you pregnant?	Yes	No
Waxing	Yes	No	Chemical Peel	Yes	No	Are you nursing?	Yes	No

History of blistering sunburns _____ Do you use sunscreen? _____ SPF _____

Sun exposure time: Occupational _____ hours/week Recreational _____ hours/week

Have you ever used Retin-A? _____ Strength? _____ How long? _____ Reaction? _____

Facial surgery? _____ Type _____ Date _____

Major health problem? _____ Diagnosis _____ Date _____

Emergency Contact:

Name _____ Phone Number _____ Relation _____

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature

Date

Congratulations and thank you for choosing CCI. Payment is respectfully requested when services are rendered. There are no refunds for any services. Packages are to be used within 12 months of purchase. All gift certificates and credits are to be used within the month they are received or purchased. Results are not guaranteed and there will be no refunds for any services' perceived complications from treatment.

Signature

Date

SKIN TYPE WORKSHEET

PATIENT NAME:	DATE:				
SCORE	0	1	2	3	4
What is the color of your eyes?	Light blue, gray, or green	Blue, gray, or green	Blue	Dark brown	Brownish black
What is the natural color of your hair?	Sandy red	Blond	Brown, chestnut, dark blond	Dark brown	Black
What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns sometimes followed by peeling	Rarely burns	Never burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly
Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
When did you last expose yourself to the sun, tanning bed, or self-tanning creams?	More than 3 months ago	2 -3 months ago	1 -2 months ago	Less than 1 month ago	Less than 2 weeks ago
Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always
TOTAL SCORE: _____	SCORE		FITZPATRICK SKIN TYPE		
SKIN TYPE:	0 - 7		I		
	8 - 16		II		
	17 - 25		III		
	26 - 30		IV		
	Over 30		V - VI		

Carolina Cosmetic Institute

FINANCIAL POLICY

Thank you for choosing Carolina Cosmetic Institute for your facial plastic surgery and skin care needs. Our goal is to make your surgical/medical experience a pleasant one. For your convenience, and to avoid any future confusion, we would like to outline our financial policies and procedures for you.

Consultation

A consultation is scheduled from your initial telephone call. This consultation is designed to meet and discuss your surgical and/or skin care needs, outline the procedure or treatment options, and inform you of the fees. If you should need to cancel your appointment, we will require forty-eight (48) hours or two business days notice. Cancellations after this time will be charged the entire consultation fee. The fee for our cosmetic consultation is \$50. (*will be applied to your surgery fee if surgery is scheduled*)

Payment Options

Carolina Cosmetic Institute is a fee for service practice only; payment for all services is required at the time of service. We accept Visa, MasterCard, personal checks and cash.

Please be aware that we will add a \$50.00 charge to your account for returned checks and we reserve the right to request future payments in the form of certified bank check or credit card. We reserve the right to send all accounts with balances over 60 days old to an outside collection agency. All accounts sent to collections will be charged a \$50.00 processing fee and any additional fees associated. You may be responsible for all reasonable collections and attorney costs incurred.

Scheduling

After your consultation, if you decide to go ahead with surgery you will work with our cosmetic patient coordinator to select a date for your surgery.

Pre-Payment

There is a deposit required before the date selected can be reserved exclusively for you. The deposit is \$500.00 or 10% of surgery cost whichever is greater. This is a non-refundable deposit. This fee is used to cover the booking and scheduling expenses involved with your surgery. This amount will be deducted from your total cost.

Pre-Surgical Visit

Prior to surgery, usually (2) weeks, you will meet with our cosmetic patient coordinator and Dr. Gunnlaugsson. We will explain all pre-operative instructions, order lab tests required, review your surgical procedure and post-operative limitations with you, and give you your post-operative prescriptions with instructions for their use. Post-operative appointments are scheduled at this time. Any questions you may have will be answered at this consult.

Surgery Final Payment

Two (2) weeks prior to surgery, you will be expected to pay the remaining balance due on your account. We accept: Visa, MasterCard, Money Orders, Cashiers Checks, personal checks (*only accepted if paid 2 weeks prior to surgery*).

Cancel Policy: If for any reason, medical or personal, you cancel two weeks or less prior to your scheduled surgery date fees will be charged as follows:

- Two (2) weeks prior to surgery – 10% or \$500 whichever is greater of your surgery fee for expenses incurred.
- One (1) week prior to surgery – 25% of surgical fee
- One (1) day (24 hours) prior to surgery – entire surgical fee.

If you have any questions, the staff will be happy to assist you. We look forward to caring for you.

I certify that I have read and understand the financial policy of Carolina Cosmetic Institute and agree to abide by the policy. Please sign and date.

Financial Guarantor Signature: _____ Date: _____

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CONSENT TO USE PHOTOGRAPHS

I understand that photographs will be taken periodically throughout my treatments. These photographs will be used to monitor progress and other factors. I understand that failure to consent to these photos will give Carolina Cosmetic Institute the right to decline my treatment.

Patient Signature: _____ Date _____

I grant Carolina Cosmetic Institute the right to use photographs of me, in the following areas:
(initial all/any for use)

- _____ Website for Consumers
- _____ Newsletter to be sent to patients
- _____ Practice brochures
- _____ Public relations material
- _____ Seminars
- _____ Patient before and after photo information sheets

I understand that by signing below Carolina Cosmetic Institute need not approach me again for authorization on these photos.

(Patient Full Name – Please Print)

(Patient Signature)

(Witness Full Name – Please Print)

(Witness Signature)

(Date)

(Date)