

Cosmetic Interest Questionnaire

Please complete the following form and return to the front desk so that we may best serve your needs.

Patient Name: _____ Date: _____

For the following statements, please check off the areas that interest you at this time:

YES ___ NO ___ I would like to be contacted for further information, events and promotions

YES ___ NO ___ I would like to improve the condition and appearance of my skin.

YES ___ NO ___ When looking at my face in the mirror, I believe I look older than my true age.

YES ___ NO ___ I am interested in surgical procedures for body shaping and sculpting.

YES ___ NO ___ I am interested in non-surgical options to correct fine lines & wrinkles.

YES ___ NO ___ I am interested in rejuvenating my eyes.

YES ___ NO ___ I am interested in contouring and re-shaping my nose.

YES ___ NO ___ I am interested in full face rejuvenation.

YES ___ NO ___ I am interested in non-surgical procedures for body shaping and sculpting.

YES ___ NO ___ I would give consent for part of my treatment to be photographed or filmed for social media

How did you hear about our office? (Please check)

Internet Search

Real Self

News Segment

Word of Mouth

Instagram

Facebook

Twitter

YouTube

Staff

Seminar

Patient _____

Dr. Referral _____

Magazine _____

Hair Salon / Stylist _____

Other _____

DANIEL I. SHAPIRO, MD, F.A.C.S.
SHAPIRO AESTHETIC PLASTIC SURGERY AND SKIN KLINIC

PATIENT DATA

Patient Name _____ Date _____

Birthdate _____ Age _____ Marital Status _____

Address _____ City _____

State _____ ZIP _____ E-Mail _____

Occupation _____

Home Telephone _____ _____ may contact me _____ may leave a message

Office Telephone _____ _____ may contact me _____ may leave a message

Mobile Telephone _____ _____ may contact me _____ may leave a message

Personal Goals

I am here today to discuss: _____

My goals are to improve my appearance by: _____

I would describe the present condition I wish to improve as: _____

Background

I have decided to consult with Dr. Shapiro because: _____

I have consulted with the following physicians, friends or family about my goals: _____

I have the following skin conditions:

- | | | |
|---|---|--|
| <input type="checkbox"/> Hyperpigmentation | <input type="checkbox"/> Expression lines | <input type="checkbox"/> Sensitive skin |
| <input type="checkbox"/> Melasma | <input type="checkbox"/> Acne | <input type="checkbox"/> Irregular moles or skin growths |
| <input type="checkbox"/> Sun damage/brown spots | <input type="checkbox"/> Facial veins | <input type="checkbox"/> Enlarged pores |
| <input type="checkbox"/> Facial wrinkles | <input type="checkbox"/> Rosacea | |

I currently use the following skin care products: _____

Patient Name _____ Date _____

Whom may we contact with regard to your medical conditions?

Primary Care Physician: _____ Telephone: _____

Address: _____

Whom may we contact in an emergency?

Name: _____ Relationship: _____

Telephone: _____ Mobile: _____

Address: _____

Lifestyle and Personal History:

I presently smoke (electronic included)	Yes	No	I have smoked	Yes	No
I presently use tobacco products	Yes	No	I have used tobacco products	Yes	No
I use recreational drugs	Yes	No	I have used recreational drugs	Yes	No

My regular exercise routine (type and frequency): _____

I consume alcoholic beverages (amount and frequency): _____

I take the following vitamins/herbal supplements (type and dosage): _____

Health history:

I regularly take the following prescription/over-the-counter medications (type and dosage): _____

I presently take the following prescription/over-the-counter medications (type, dosage and purpose): _____

I am allergic to the following medications: _____

I have the following additional allergies: _____

I have had a staph infection in the past: _____ If yes, please explain: _____

I am presently under a doctor's care for the following conditions: _____

I have the following medical conditions: _____

I would describe my present state of health as: _____

I have had the following treatments:

___ Non-cosmetic surgery (list type and date) _____

___ Aesthetic or cosmetic surgery (list type and date) _____

___ Botox® or similar treatment (botulinum type/regions treated/frequency/date of last treatment) _____

___ Injected or implanted fillers (filler type/regions treated/date of last treatment) _____

___ Chemical peel (define the type of peel and concentration) _____

___ Dermabrasion or dermaplaning (date of last treatment) _____

___ Laser resurfacing (date/outcomes) _____

___ Photorejuvenation (date/outcomes) _____

___ Other energy-based treatments (i.e. Thermagge®) (date/outcomes) _____

I attest the above history is completed to the best of my knowledge and understand and accept that my failure to disclose any of the above information can adversely affect a prescribed course of treatment to meet my goals, my safety, or the outcome of any treatment I elect to undergo with Daniel I. Shapiro, MD, or any member of his staff, including the Paradise Valley Skin Clinic.

Patient signature

Date

Please check any of the following conditions that you now have (or have ever had):

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Nervous disorders |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Allergy Problems | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Allergy to <u>local</u>
anesthetics | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergy to latex | <input type="checkbox"/> Joint pains/arthritis | <input type="checkbox"/> Faint easily |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Sun poisoning | <input type="checkbox"/> Bowel disorder | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cold sores/fever blisters | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Positive skin test for
tuberculosis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Exposure to AIDS | <input type="checkbox"/> Yeast infection |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Blood clot in leg | <input type="checkbox"/> HIV/Positive HIV test |
| <input type="checkbox"/> Abnormal chest x-ray | <input type="checkbox"/> Blood clot in lung | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Sleep disorders | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Extreme weight loss/gain |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Vision Trouble | <input type="checkbox"/> Bruising easily | <input type="checkbox"/> Difficulty urinating |
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Frequent nosebleeds | <input type="checkbox"/> Keloids/excessive scarring |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Foot or ankle swelling | <input type="checkbox"/> Sensitive Skin |
| | <input type="checkbox"/> Leg cramps | |

My last tetanus shot was: _____

I would describe my present state of health as: _____

Female Patients:

I AM / AM NOT now pregnant

I AM / AM Not now nursing

I have given birth to _____ children I have had _____ Cesarean deliveries

I take/use the following contraceptives or hormone replacement therapy _____

My last mammogram was on _____ and was reported to be: _____

I attest the above health history is completed to the best of my knowledge and understand and accept that my failure to disclose any medical condition can adversely affect my safety or the outcome of any treatment I elect to undergo with Daniel I. Shapiro, MD, or any member of his staff, including the Paradise Valley Skin Clinic.

I consent that the above information is not a substitute for diagnostic medical testing that may be required prior to any surgical or other treatment. I consent that the above information is strictly used for screening purposes to determine my overall health.

Patient Signature

Date

DANIEL I. SHAPIRO, MD, F.A.C.S.
SHAPIRO AESTHETIC PLASTIC SURGERY AND SKIN KLINIC

PATIENT PRIVACY and CONSENT
FOR PURPOSES OF TREATMENT,
PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby consent to the use or disclosure of my protected health information by the practice of Daniel Shapiro, M.D., hereinafter referred to as ("Practice"), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. I understand that payment for such procedures may be requested in advance of any treatment. I understand there are no warranties, implied or otherwise, to the outcomes any treatment or procedure.

I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Practice is not required to agree to the restrictions that I may request. However, if the Practice agrees to the restrictions that I request, such restriction is binding on the Practice.

I have the right to revoke this consent, at any time, in writing, except to the extent that the Practice has taken action in reliance on this consent.

My "protected health information" means health information and my demographic information collected from me and created or received by: the Practice, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me.

I understand I have a right to review the Practice's *Notice of Privacy Practices*, which has been offered to me by the practice, prior to signing this document. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This *Notice of Privacy Practices* also describes my rights and the practice's duties with respect to my protected health information. The *Notice of Privacy Practices* for the Practice is available at the offices of the Practice: 5410 N. Scottsdale Road Suite F-100 Paradise Valley, Arizona 85253.

Terms of the *Notice of Privacy Practices* may change. If changes are made, I may obtain a revised *Notice of Privacy Practices* by: calling the offices of the practice requesting a revised copy be sent in the mail, or by requesting one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority

Signature of Practice Representative and Witness