PATIENT INFORMATION

Please full out as accurately as possible. *Only required for surgery

First Name	M.I.	Last Name	Social Security Number*
Street Address		Apt. #	Driver License Number
City	State	Zip	-Office Use- Med Spa Surgery
Email	Home Phone	Mobile Phone	Work Phone
Date of Birth	Marital Status Single Married Divorced Widowed Separated	Sex Male Female	Age
Occupation	Employer		Employer Phone
Primary Care Physician		Primary Care Physician Phone	
Emergency Contact Name	Emergency Contact Phone		Relationship To Patient

Were you referred to us? Yes No	Referred by:
How did you hear about us? Internet/Online Radio Flyer Drive By Word of Mouth List Other:	
Would you like to receive special offers & promotions through email? Yes No	

Reason for visit:

Have you ever been seen for the same reason elsewhere?	Yes No	Have you had previous surgery?	Yes No
Are you generally in good health?	Yes No	List previous surgery:	
Are you presently under a doctor's care?	Yes No		
Are you on medication?	Yes No	List medication:	

Do you have or have had any of the following?

Heart Disease?	Yes No	Eczema?	Yes No
Liver Disease?	Yes No	Bleeding Disorders?	Yes No
Lung Disease?	Yes No	Do cuts on your skin heal normal?	Yes No
Seizures?	Yes No	Do you have a tendency towards Keloids?	Yes No
Diabetes?	Yes No	Have you ever had an adverse reaction to Anesthesia?	Yes No
High Blood Pressure?	Yes No	Allergic to Latex?	Yes No
Hay Fever?	Yes No	Take Asprin or Blood Thinner?	Yes No
HIV?	Yes No	Are you allergic to any medications?	Yes No
Hepatitis B or C?	Yes No	List allergies:	

Patient Signature	Date

Pham Institute of Esthetic
4355 Hunters Park Lane Orlando FL 32827
Phone: 407-965-2558 Fax: 888-283-3503

COSMETIC QUESTIONNAIRE

What brings you to our office today?

Do you have any of the following concerns?

Frown line on brow, forehead, eyes, or nose?	Yes	No	Hyperpigmentation?	Yes	No
Skin pigment, sun spots?	Yes	No	Acne scars?	Yes	No
Fine lines, wrinkles, sagging skin?	Yes	No	Rough skin texture?	Yes	No
Dark circles under eyes?	Yes	No	Hollows around nose & mouth?	Yes	No
Freckles?	Yes	No	Cellulite?	Yes	No
Facial Hair?	Yes	No	Fat in belly, flanks, arms, legs, chest or neck?	Yes	No
Age Spots?	Yes	No	Breast Size/Shape?	Yes	No
Tired looking skin?	Yes	No	List Other Concern?		

Are you interested in learning more about the following?

Botox	Yes	No	Facelift	Yes	No	Eyelift	Yes	No
Skin Care Products	Yes	No	Necklift	Yes	No	Gynecomastia (Male Breast Reduction)	Yes	No
Spider Vein Treatments	Yes	No	Rhinoplasty (nose correction)	Yes	No	Breast Augmentation	Yes	No
Facials/Eye Treatments	Yes	No	Chin Augmentation	Yes	No	Breastlift	Yes	No
JUVEDERM Injectable Gel	Yes	No	Fat Transfer	Yes	No	Liposuction	Yes	No
Skin Rejuvenation	Yes	No	Otoplasty (Ear Surgery)	Yes	No	Thigh/Arm Lift	Yes	No
Latisse	Yes	No	Contouring after Weight Loss	Yes	No	Labiaplasty	Yes	No
Restylane	Yes	No	Tummy Tuck	Yes	No	Laser Hair Removal	Yes	No

Patient Signature	Date
Print Patient Name	

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POLICIES

Office Hours: Normal business hours are 9:00AM to 5:00PM.

Appointments: All treatments are scheduled by appointment. It is our policy to book ample time for your treatment and we do our best to minimize waiting time. If you should need to cancel or reschedule an appointment, we request at least ***24 hours advance notice****, otherwise you will be responsible for the visit fee.

Registration Materials: In order to provide optimum care we request that you complete a medical history questionnaire prior to your visit to the office. Please bring a complete list of medications to your visits. If you wear contact lenses, you should bring a case for them as well as your glasses.

Insurance Coverage: The cost of cosmetic procedures ***is not covered*** by insurance plans, and thus is the full responsibility of the patient.

FINANCIAL RESPONSIBILITY

In the event that *Pham Institute of Esthetic* is required to procced with any collection proceedings, I agree to be responsible for all reasonable billing fees associated with the collection of my debt, including but not limited to 1.5% per month interest on the outstanding balance, plus attorney/legal, and/or collection fees (up to 33.3%). I agree that I will be responsible to pay *Pham Institute of Esthetic* for all services rendered.

MISSED APPOINTMENT POLICY

Any appointment missed, cancelled, or rescheduled within less than 24 hours from the time of your scheduled appointment will be subject to the following fees.

MISSED APPOINTMENT FEE = $25.00

***PLEASE NOTE.** Leaving a message with our answering service the night before a scheduled appointment does NOT constitute a 24 hours notice.*

Patient Name:	Patient Signature:	Date:
Staff Name:	Staff Signature:	Date:

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HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

I, ________________________________, understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have had the opportunity to read and understand your Notice of Privacy Practices regarding the use and disclosures of my health information (a hard copy has not been enclosed: please ask our receptionist if you wish to read the full text or receive a hard copy). I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices. I may also request in writing that you restrict how my private information is used or disclose to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

I give permission to be contacted by the following option(s):

Home Phone	Yes No
May we leave a message?	Yes No

Cell Phone	Yes No
May we leave a message?	Yes No

Work Phone	Yes No
May we leave a message?	Yes No

Mail	Yes No
Email	Yes No

I **DO NOT** give permission to be contacted by Pham Institute of Esthetic.
I assume full financial responsibility for any and all missed appointments.

Patient Signature	Date

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DR. NATHAN PHAM'S PROGRESS NOTES

PATIENT NAME			DATE	
AGE	SEX FEMALE MALE	CHILDREN	HEIGHT	WEIGHT

PHMX:

PSHX:

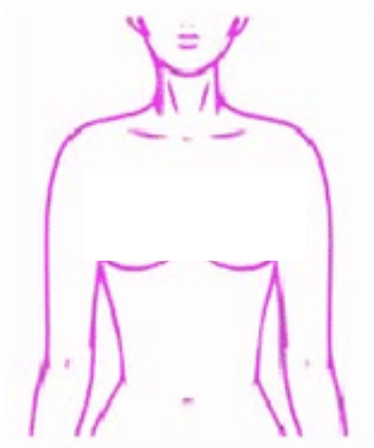
SHX:

SMOKER YES NO	QUANTITY	ALCOHOL YES NO	QUANTITY

ALLERGIES NKDA OTHER:

CURRENT MEDICATIONS

CUP SIZE NO. A B C D DD	PANT SIZE	BREAST FEED YES NO



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