ADVANCED
PLASTIC SURGERY CENTER

Patient Information

Date:		☐Mrs. ☐Mr. ☐Ms ☐Miss ☐Dr.
Last Name: Nickname:	First Name:	Middle Name:
Birthdate:	Age:	Sex: ☐Female ☐Male
Address: Zip:		City: State:
Cell Phone:		Home Phone:
Email Address:		Employer:
Emergency Contact: Relation:		Phone Number:
Responsible Party (if under 18):		Relationship to Patient:

How Did You Hear About Our Practice

☐ Physician:
_____

☐ Patient:
_____

☐ Family Member/Friend:
_____

☐ Other:
_____

☐ Social Media

☐ Our website

☐ Internet Search

☐ Magazine

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Reason For Visit:

Other Interests

☐ Breast Augmentation	☐ Facelift/Necklift	☐ Botox/Dysport/Xeomin
☐ Breast Reduction	☐ Eyelid Lift	☐ Filler
☐ Breast Lift	☐ Brow Lift	☐ Laser
☐ Tummy Tuck	☐ Thigh Lift	☐ Skin Rejuvenation
☐ Liposuction	☐ Arm Lift	☐ Scar Management
☐ Body Lift	☐ Gynecomastia	☐ Cellulite Treatment

Medical History

Height:	**Weight:**

☐ Abnormal Blood Pressure	☐ Heart Murmur	☐ Rheumatic Fever
☐ Anemia/Bleeding Disorder	☐ Heart Palpitations	☐ Skin Disease
☐ Anxiety/Depression	☐ Hepatitis (circle: A, B, C)	☐ Sleep Problems
☐ Arthritis/Joint Pain	☐ Hiatal Hernia (reflux)	☐ Stroke
☐ Asthma	☐ High Cholesterol	☐ Thyroid Disease
☐ Autoimmune Disease	☐ HIV/AIDS	☐ Urinary Infections
☐ Blood Transfusions	☐ Jaundice	☐ Varicose Veins/Phlebitis
☐ Bowel Disease	☐ Kidney Disease	☐ Vascular Disease
☐ Cancer (when/where: _____)	☐ Liver Disease	☐ Weight Gain (+ _____ lbs.)
☐ Diabetes	☐ Mental Illness	☐ Weight Loss (+ _____ lbs.)
☐ Epilepsy/Neurological Disease	☐ Osteoporosis	☐ Other
☐ Headaches	☐ Peptic Ulcer	

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Social History		
☐ Nicotine Use (type _____)	☐ Alcohol (oz/week _____)	☐ Caffeine (cups/day _____)
Please list current medications and supplements (include oral contraceptives and GLP-1):		
Please list any allergies:		
Please list any past surgeries and cosmetic procedures with dates:		
Pharmacy:	PCP (if applicable):	
Women Only		
☐ Pregnant	☐ Planning a Future Pregnancy	☐ Nursing

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Additional Disclosure Authority	
At Advanced Plastic Surgery Center, we respect your privacy and take great care to protect your health information. If you would like us to share your medical records or healthcare information with any individual(s), such as a family member, spouse, friend, or referring physician, please list their names below. By completing this section, you are authorizing Advanced Plastic Surgery Center to disclose your protected health information to the individual(s) you specify. This may include appointment details, treatment plans, billing information, and other relevant medical information.	
☐ Spouse Only ☐ Referring Physician ☐ Any member of my immediate family ☐ Other (please specify) _____	
Patient Signature:	**Date:**
Responsible Party Signature (if not patient):	

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Payment Policy and Appointment Terms

Our primary mission is to provide the highest quality and most comprehensive care to our patients. We are committed to making the financial aspect of your care clear and manageable by offering multiple payment options.

Payment Options

We accept cash, certified checks (no personal checks), Apple Pay, and all major credit/debit cards including Visa, MasterCard, American Express, and Discover.

We also accept financing through CareCredit® with convenient monthly payment options. Subject to credit approval, patients may qualify for no interest if paid in full within 6 or 12 months.

For cosmetic procedures, payment is required in full prior to your procedure. These terms will be outlined in your personalized quote.

Insurance Information

Advanced Plastic Surgery Center is not contracted with any health insurance plans. All services rendered will be considered out-of-network if submitted to insurance. Patients are responsible for understanding their insurance policies. While we do not bill insurance directly, we are happy to assist you in maximizing your out-of-network benefits and will provide the documentation needed for self-submission and reimbursement. Please note, our practice is unable to communicate directly with your insurance carrier.

Appointment Cancellations & No-Show Policy

To offer timely care to all patients, we require 48 business hours' notice to cancel or reschedule an appointment.

Procedure and surgery-specific cancellation and no-show fees will be outlined in your surgical quote.
As a courtesy to other patients, appointments may be rescheduled if you arrive more than 15 minutes late.

A valid credit card is required at the time of scheduling to hold your appointment.

Returned checks will incur a $35.00 processing fee.

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Patient Signature:	**Date:**
Responsible Party Signature (if not patient):	