AESTHETICA
COSMETIC SURGERY & LASER CENTER

Phillip J Chang MD

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION

<table>
<tr><td>Last Name:</td><td>First Name:</td><td colspan="2">Middle Name:</td></tr>
<tr><td>Street Address</td><td>City</td><td>State</td><td>Zip Code</td></tr>
<tr><td>Social Security Number:</td><td>Date of Birth:</td><td colspan="2">Age:</td></tr>
<tr><td colspan="2">If minor, parent's name:</td><td colspan="2">Parent's Social Security Number:</td></tr>
<tr><td colspan="2">Marital Status:</td><td colspan="2">Gender:</td></tr>
<tr><td colspan="2">Cell Phone:</td><td colspan="2">Work Telephone:</td></tr>
<tr><td colspan="2">E-Mail:</td><td colspan="2">May we send you offerings via mail / e-mail?</td></tr>
<tr><td colspan="4">Reason for Visit:
Primary Referral Source:</td></tr>
<tr><td>Emergency Contact Information:

Name:</td><td>Relationship:</td><td colspan="2">Phone:</td></tr>
</table>

MEDICAL HISTORY

<table>
<tr><td>Height:</td><td>Weight:</td><td colspan="2">Bra Size (For Breast Consultations Only):</td></tr>
<tr><td colspan="4">Medications that you are allergic to:</td></tr>
<tr><td colspan="2">Are you allergic to Aspirin?</td><td colspan="2">Are you allergic to Latex?</td></tr>
<tr><td colspan="4">Current Medications:

Oral, Topical, & Herbal Supplements:</td></tr>
<tr><td colspan="2">Do you Smoke?
If so, how much?
Do you use Drugs?</td><td colspan="2">Do you drink Alcohol?

If so, how much?
Are you Pregnant / Breast Feeding?</td></tr>
<tr><td colspan="4">Previous Surgeries:

Procedure: Procedure:

Procedure: Procedure:
If you have ever had a problem with Anesthesia:</td></tr>
</table>

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Please check all of your past and current Medical Conditions:

- ☐ Anemia or Blood Disorder
- ☐ Auto-Immune Disorder
- ☐ Diabetes
- ☐ Eye Disease/ Dry Eyes
- ☐ Hepatitis or Liver Disease
- ☐ Nerve Disorder
- ☐ Urology Disorder
- ☐ Arthritis
- ☐ Cancer
- ☐ Eating Disorder
- ☐ Gastroenterology Disorder
- ☐ High Blood Pressure
- ☐ Skin Disorder
- Other
- ☐ Asthma or other Lung Disorder
- ☐ Cold Sores
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Thyroid Disorder

SERVICES OFFERED

Please check all the procedures about which you would like to receive more information from our staff:

Cosmetic Surgery

- Abdominoplasty (Tummy Tuck)
- ☐ Blepharoplasty
- ☐ Breast Augmentation/Lift/Reduction
- ☐ Liposuction
- ☐ Face/Neck/Browlift
- ☐ Rhinoplasty (Nose Job)
- ☐ Mommy Makeover
- ☐ Labiaplasty
- ☐ Umbilicoplasty (belly button)
- ☐ Otoplasty (ear surgery)
- ☐ Lesion/ Cyst/ Nevus
- ☐ Fat Transfer

Non-Surgical Procedures

- ☐ Diva
- ☐ Botox
- ☐ Fillers
- ☐ Facial Lasers
- ☐ Laser Hair Removal
- ☐ PRP
- ☐ SculpSure
- ☐ miraDry
- ☐ Kybella
- ☐ Medical Facial
- ☐ Chemical Peel
- ☐ Microneedling
- ☐ Hormone Replacement Therapy

OFFICE POLICIES

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and other health plans to Dr. Chang. I understand that I am financially responsible for all office and emergency room charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment and assume liability for collection costs. Whether or not my insurance company pays in full, a portion, or no portion of my medical bills, is a matter between me and my insurance carrier. Unless other arrangements have been made, any unpaid balance is due within 30 days of treatment. Payment is accepted in the form of cash, check, credit card, or money order. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for payment. I hereby give my permission to have the appropriate photographs taken for the purpose of completing Dr. Chang's records. These records are confidential and will not be presented without both my and Dr. Chang's written permission.

X ______________________________________

Patient Signature (Parent, if minor) **Date**