CAROLINA
FACIAL PLASTICS

6849 Fairview Rd. Suite 200, Charlotte, NC 28210
(704) 323-5090 • CarolinaFacialPlastics.com

Date: _____ Name (Last, First): _____

Date of Birth: _____ Age: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

May we send you information about new treatments or specials? ☐ YES ☐ NO

EMERGENCY CONTACTS

In case of an emergency, please contact: _____

Phone number: _____

REQUESTED SERVICE

What are you here for today? _____

REFERRAL

Where did you hear about us? _____

Referred By: _____

Can we thank the person that referred you to us? ☐ Yes ☐ No

Which procedure(s) are you interested in learning more about? **(Check mark all that apply)**

☐ Medical Grade Skincare	☐ Facial Fillers	☐ Brow Lift
☐ Facial / Chemical Peel	☐ Kybella (Double Chin Tx)	☐ Eyelid Rejuvenation
☐ Microneedling / PRP	☐ Lip Augmentation	☐ Face / Neck Lift
☐ Laser Skin Rejuvenation	☐ Chin / Cheek Implants	☐ Buccal Fat Excision
☐ Laser Skin Tightening	☐ Non-Surgical Rhinoplasty	☐ Rhinoplasty
☐ Facial Vein Treatment	☐ Keloid / Mole Excision	☐ Otoplasty
☐ Botox / Dysport / Xeomin	☐ Sun Spot / Pigment Removal	☐ Other

The Carolina Facial Plastics experience is about YOU. **Please share a few details if you are comfortable.**

Profession/Employer? _____ Favorite skincare treatment? _____

Favorite skincare product? _____ Favorite hobby/pastime? _____

Staff notes to make your experience fantastic: _____

_____

Signature: _____ Date: _____

PERSONAL HISTORY QUESTIONNAIRE Date: _____

Name (Last, First): _____ Marital Status: ☐S ☐M

ALLERGIES (If you are allergic to any medications or foods, please list them here)

_____

PAST MEDICAL HISTORY (Please list all medical problems you have currently or have had in the past year)

_____

_____

PAST SURGICAL HISTORY (Please list all surgeries you have had)

_____

_____

DO YOU HAVE DRY EYES? ☐ Yes ☐ No

MEDICATIONS (Please list any medications you are taking, including herbal therapies, topical creams, vitamins, protein shakes or protein bars) _____

_____

_____

***If you have a list of medications, please attach on back of form.**

SOCIAL HISTORY

Do you use nicotine? ☐ Yes ☐ No How many packs per week? _____

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? _____

Do you vape? ☐ Yes ☐ No How often per week? _____

WOMEN ONLY

Is there a chance you may be pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No How many children do you have? _____

MEDICAL SKINCARE ASSESSMENT

Have you ever been treated for a skin condition? ☐ Yes ☐ No

If yes, what condition? _____

Have you ever had a cold sore? ☐ Yes ☐ No Do you use Retinol? ☐ Yes ☐ No

Have you used Accutane in the last year? ☐ Yes ☐ No

How do you tan? ☐ Burn ☐ Usually Burn ☐ Sometimes Burn ☐ Rarely Burn ☐ Never Burn

Have you ever had gold therapy? ☐ Yes ☐ No Do you have any tattoos? ☐ Yes ☐ No

What is your ethnic background? _____

Do you have a history of scarring or keloids? _____

What are you currently using for skincare? _____

Signature: _____ Date: _____

Notice of Privacy Practices and
Patient Consent For Use and Disclosure of Protected Health Information

Signature: _____ Date: _____

I understand that under the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Carolina Facial Plastics PLLC may use or disclose my protected health information for treatment, payment or health care operations -- which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Carolina Facial Plastics PLLC has a detailed document called the 'Notice of Privacy Practices.' It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Carolina Facial Plastics PLLC will provide me with the most current Notice of Privacy Practice.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Carolina Facial Plastics PLLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Carolina Facial Plastics PLLC has taken action relying on this consent.

Signature: _____ Date: _____

Relationship to patient (if signed by another party): _____ Date: _____

You may obtain a copy of our Notice of Privacy Practices, including revisions of our Notice at any time by contacting Carolina Facial Plastics PLLC, 6849 Fairview Rd, Suite 200, Charlotte, NC 28210, 704-323-5090.

You may be contacted by Carolina Facial Plastics PLLC to remind you of any appointments, healthcare treatment options, marketing, or other health services that may be of interest to you. We will contact you via telephone, text message and email for appointment reminders.
Initials: _____

Is there anyone we can leave a message with? Yes / No (If yes, please list first and last names)

_____ _____

_____ _____

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments only. Yes / No (If yes, please list first and last names)

_____ _____

Patient signature: _____ Date: _____