CAROLINA FACIAL PLASTICS PLLC
6817 Fairview Rd. Charlotte, NC 28210
(704) 842-3644 • CarolinaFacialPlastics.com

Date: _____ Name (Last, First): _____
Date of Birth: _____ Age: _____
Home Address: _____
Home Phone: _____ Cell Phone: _____
Email: _____

☐ I want to opt out on information about new treatments or specials.

EMERGENCY CONTACT

Name: _____ Phone number: _____

REQUESTED SERVICE

What are you here for today? _____

REFERRAL

Where did you hear about us?

☐ Internet - Google, Website, Yelp, Facebook, Instagram, Youtube. Please clarify: _____
☐ Patient Referral. Please provide name: _____
☐ Doctor Referral. Please provide name: _____
☐ Other - Event, Newsletter, TV/Media. Please clarify: _____

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)

Surgical

☐ Brow / Forehead Lift
☐ Cheek / Buccal Fat Excision
☐ Chin / Cheek / Jaw Implants
☐ Eyelid Rejuvenation
☐ Face / Neck Liposuction
☐ Facelift / Necklift / Minilift
☐ Fat Grafting
☐ Keloid / Mole Excision
☐ Otoplasty Ear Surgery
☐ Rhinoplasty / Revision Rhinoplasty

Injectables

☐ Botox® / Dysport®
☐ Eye Bags / Under Eye Hollows
☐ Facial Fillers
☐ Kybella® (Double Chin Tx)
☐ Lip Augmentation
☐ Liquid Face / Eye Lift
☐ Non-Surgical Rhinoplasty

Hair Loss

☐ Propecia®
☐ PRP Injections
☐ Supplements
☐ Topical medications

Aesthetician

☐ Facials / Chemical Peels
☐ Laser Skin Rejuvenation
☐ Laser Skin Tightening
☐ Lash Growth
☐ Medical Grade Skincare
☐ Microneedling
☐ Sun Spot / Pigment Removal
☐ Vampire Facial® / Facelift

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: _____

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PERSONAL HISTORY QUESTIONNAIRE

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

Marital Status: ☐ Single ☐ Married

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

_____

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) _____

_____

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

_____

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No ☐ How many drinks per week?
Do you have bleeding tendencies? ☐ Yes ☐ No
Do you vape or use any other nicotine products? ☐ Yes ☐ No
If yes please list _____

MEDICAL SKINCARE ASSESSMENT

Have you ever taken Accutane? ☐ Yes ☐ No
Do you have dry eyes? ☐ Yes ☐ No
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
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? _____
Scar/Keloids easily? ☐ Yes ☐ No
What are you currently using for skincare? _____

_____

WOMEN ONLY

Is there a chance you may be pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No
How many children do you have? _____

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

I understand that under the Health Insurance and Portability and Accountability Act of 1996 (HIPPA), 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, 6817 Fairview Rd, Suite 200, Charlotte, NC 28210, 704-842-3644.

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: _____