Detroit Face and Body

Patient Information

◯ M ◯ F Marital Status _____ Birthdate _____ Referred By _____

Last Name _____ First Name _____ Middle _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____ Preferred # to Call _____

Email Address: _____

Race_____ Ethnicity_____ Preferred Language_____

Pharmacy Name_____ Address _____ City_____

Pharmacy Phone #_____

Patient record of disclosure:

Home: ____ Ok to leave message with detailed information ____ Leave message with call back number only

Work: ____ Ok to leave message with detailed information ____ Leave message with call back number only

Cell: ____ Ok to leave message with detailed information ____ Leave message with call back number only

	Yes	No	
Do you or have you ever smoked? If yes , years?____			Number packs/per day_____ Last Smoked?_____
Do you drink alcoholic beverages on a weekly basis			Yes, How much?_____
Do you use: Marijuana Cocaine Heroin other			If yes, how often_____ When was the last time used_____
Do you have a Medical Marijuana Card			

Do you have or have you ever had any of the following?	**Yes**	**No**		**Yes**	**No**
Diabetes			History of Bleeding or Bruising		
High Blood Pressure			Are you pregnant?		
Do you get cold sore/fever blisters			Are your breastfeeding?		

List Allergies to medication; _____ **LATEX ALLERGY?:** _____

_____

_____

_____

List all medications you are taking and dosage _____ Medication continued _____

_____ _____

_____ _____

_____ _____

Authorization and Release

I certify that I have read and understood the above information to the best of my knowledge. I acknowledge full financial responsibility for services rendered by Detroit Plastic Surgery. I voluntarily give consent to cosmetic treatment risk factors. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I have read and fully understand the above consent for treatment and financial responsibility. I understand that all purchases are **nonreturnable**. I understand I have a right to review the HIPPA Notice of Privacy Practice Brochure.

Signature:_____ Date: _____ Guardian's Name _____
(if patient is a minor)