PLASTIC SURGERY CENTER OF DULUTH
and Aesthetic Services

Date:_____

Name:_____**DOB:**_____**Age:**_____

Address:_____**City/State:**_____**ZIP:**_____

Home phone:_____**Cell phone:**_____**Work phone:**_____

Email Address:_____**Occupation:**_____

SSN (Needed for VA insurance):_____

Emergency contact:

Name:_____**Relationship:**_____**Phone number:**_____

Primary care physician:_____**Referring physician:**_____

Preferred Pharmacy/Location:_____

Reason for visit:_____

Gender: M / F Height:_____**Weight:**_____

<u>Current Medications/Doses:</u> ☐ if taking any aspirin, ibuprofen, advil and list below

_____ _____

_____ _____

_____ _____

<u>Allergies/Reactions:</u> ☐ check if no known allergies

_____ _____

_____ _____

Weight loss or Diabetes Medications:

Please circle if taking any of these medications: MOUNJARO (TIRZEPATIDE), OZEMPIC (SEMAGLUTIDE), RYBEISUS (SEMAGLUTIDE), WEGOVY (SEMAGLUTIDE), TRULICITY (DULAGLUTIDE), BYDUREON, BYETTA (EXENATIDE), VICTOZA (LIRAGLUTIDE), SAXENDA (LIRAGLUTIDE), ADLYXIN (LIXISENATIDE)

Medical History: **Please circle all that apply**

High Blood Pressure	Bleeding/ clotting disorder	COPD	Sleep Apnea	Fracture of facial bones	Numbness or paralysis
Heart Condition	Currently on blood thinners	Asthma	Hepatitis	False teeth	Neurological Disease
Stroke	Anemia	Lung Disease	Diabetes	Muscle weakness	AIDS/HIV
Pacemaker	Kidney Disease	Shortness of breath	Thyroid Disorder	Fracture of neck/back	Recent abnormal EKG/XRay

Current or past cancer: Y N If yes, what type:_____

Prosthetic Device: Y N If yes, what type:_____

Previous Surgeries/Serious Injuries (please give approximate dates)

_____ _____

_____ _____

_____ _____

Please list any other conditions not listed above:_____
_____

Social History: Please circle one
Tobacco use: Yes / No / Former: Packs/day_____ If former smoker, how long smoke free_____
Hx of Substance abuse: Yes / No Recreational drug use: Yes / No
Alcohol use: Yes/ No drinks per day:_____

Release of Personal Information

I, _____, hereby authorize representatives of of Plastic Surgery Center of Duluth to speak with the following person(s) regarding my medical information (appointments, billing, etc).

Name:_____Relationship:_____Phone number:_____

Name:_____Relationship:_____Phone number:_____

▢ Please check box if you **DO NOT** authorize representatives of Plastic Surgery Center of Duluth to speak to anyone besides you.

Financial Responsibility: All professional services rendered are the responsibility of the patient/guarantor.

Surgery covered by insurance: You will be responsible for your copayment, deductible, and/or coinsurance. Please be prepared to pay your required portion.
Please initial:_____

Informed consent patient before and after imaging:

During the course of the consultation, I may have been shown before and after photos of actual patients. I understand that those pictures are solely for the purpose of illustration of possible outcomes. I understand that any type of surgical procedure is related to my individual characteristics and health. Because of the differences in how individual living tissues react to surgery, there may be no relationship between the images observed and my actual final result.
Please initial: _____

Photographic images:I authorize Dr. Saldana and his staff to photograph relevant areas of my body for documentation of care. I understand that this will be part of my medical record and will be used for diagnosis, treatment or educational purposes. **Please initial:_____**

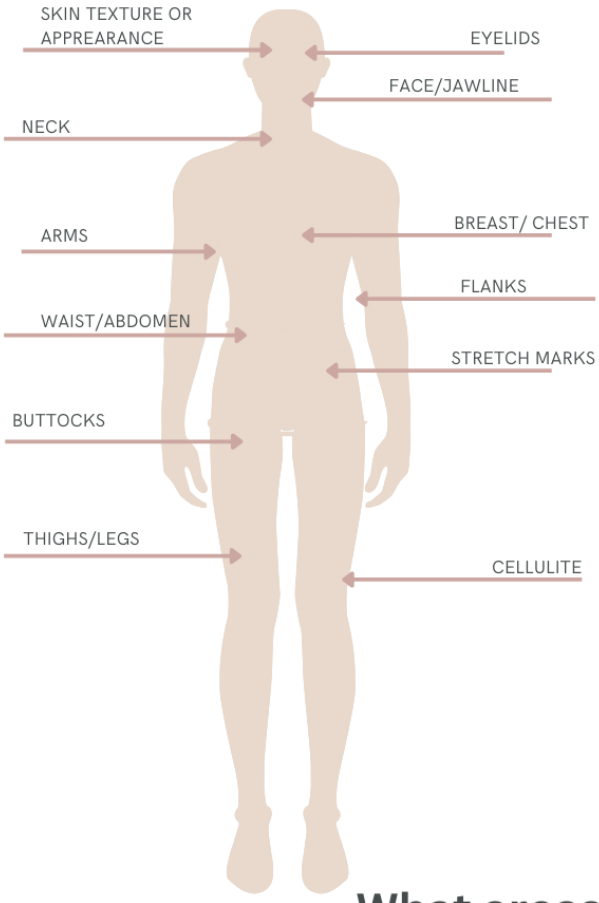
I consent to my photographs being used on Facebook or Instagram for before and after photos.
Please initial: _____

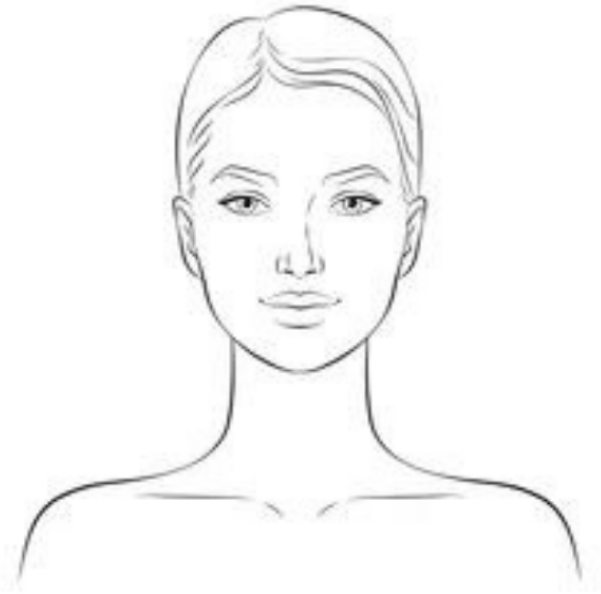
Authorization for treatment and insurance authorization:

I authorize the Plastic Surgery Center of Duluth to give me reasonable and proper care by today's standards. I, the patient or responsible party, authorize release of medical information for the purpose of processing medical claims. I hereby authorize my insurance company to pay claims directly to the physician. I am financially responsible for non-covered claims.

Signature of Patient/Guardian_____Date:_____

CIRCLE AREAS OF CONCERN





MARK AREAS OF CONCERN

What areas would you like to discuss today?

Loose, saggy, or excess skin	Weight loss	Chemical peel	Scar revision
Excess fat	Volume loss	Back or flanks	Botox/fillers
Lack of muscle tone	Stretch marks	Legs/thighs/hips area	Drooping brows or drooping eyelids
Cellulite	Age, sun, or brown spots	Abdominal area	Neck wrinkles or lines
Noninvasive procedures	Skin care advice or skin care products	Breast size	Facial contouring
Body contouring	Facial redness	Facial drooping or fullness	Jowls or weak jawline
Thin or uneven lips	Skin texture or appearance	Nose size or shape	Double chin

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Refund Policy

Gift Cards:

- Gift cards are **non-refundable** and cannot be redeemed for cash or transferred to another individual.
- Gift cards do not expire and may be used toward any eligible services or products offered at our practice.
- Promotional gift cards or bonus credits issued during special events or promotions may have additional restrictions, as stated at the time of issuance.

Aesthetic Services:

- Payments for aesthetic services are **non-refundable** once the service has been provided.
- Prepaid packages for treatments are also non-refundable; however, unused portions may be applied toward other services or products within our practice.
- If you are dissatisfied with the results of a service, we encourage you to contact us within [specific time frame, e.g., 7-14 days] to discuss your concerns. We will work with you to address the issue, as patient satisfaction is our priority.

Thank you for understanding our policies, which allow us to maintain the highest standards of care and service for all our patients. If you have any questions, please contact us at

(218) 215-8990 or email: info@duluthplasticsurgerycenter.com

Print Name: _____ Date: _____

Signature: _____