E P I O N E
MEDICAL CORPORATION

*** required information**

***First Name**_____ MI_____* **Last Name** _____Maiden Name_____

* **Date of Birth** _____***Gender** M / F ***Marital Status** Single / Married /Divorced /Widowed

***Home Address (No PO Box please)** _____

City _____ State _____ Zip Code_____

Mailing address *if* different than above_____

City _____ State _____ Zip Code _____

Cell Phone** _____Email Address** _____

***What is your preferred contact?** Please circle one Home Phone Business Phone Cell Phone

***How did you hear about us?**_____
(Please be specific. If referred by one of our current patients, please write down the patient's name)

***EMERGENCY CONTACT**

First Name _____Last Name _____ Relationship _____

Cell Phone_____ Home Phone_____

***What medical problems do you have now or have you had in the past?**

Past Medical History:

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Epilepsy
- ☐ Scarring/Keloids
- ☐ Hormonal Imbalance
- ☐ Autoimmune Disorders
- ☐ Lupus
- ☐ Acne
- ☐ Cold Sores/Shingles
- ☐ Immune Compromised
- ☐ Pregnancies
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic Pain
- ☐ Chronic Depression
- ☐ Psychological Disorders

_____
_____
_____

***Have you had any surgeries in the past?** Yes____No____ Please explain:_____

_____

Past Cosmetic Surgeries/ Procedures:

- ☐ Rhinoplasty (nose)
- ☐ Breast (Augmentation, Reduction, Lift)
- ☐ Liposuction: areas _____
- ☐ Tummy Tuck ___
- ☐ Facelift
- ☐ Body Implants
- ☐ Chin / Cheek Implant
- ☐ Blepharoplasty (eyes)
- ☐ Hair transplant
- ☐ BBL
- ☐ Silicon Injections / Permanent Filler
- ☐ Dermal fillers
  - Area(s) treated
  - Date treated
  - Facility Name
- ☐ Fat transfer to face
- ☐ Botox
- ☐ Kybella:
- ☐ Lasers
  - Area(s) treated
  - Date treated
  - Facility Name

Results

- ☐ Better than Expected
- ☐ As Expected
- ☐ Worse than Expected – *please explain:* _____
- ☐ Had Major Complications – *please explain:* _____

***Are you taking any medications?** Yes / No … If so please list (including birth control pills, hormone, over the counter medications, and/or vitamins)

Current Medications

- ☐ Tranquilizers
- ☐ Sleeping Pills
- ☐ Antidepressants
- ☐ Pain killers
- ☐ Anti-Seizure
- ☐ Psych Meds
- ☐ Hormonal Replacement
- ☐ Hormonal Contraceptives
- ☐ Antibiotics
- ☐ Accutane
- ☐ Blood Thinners
- ☐ No Current Medications

_____

_____

_____

***Are you pregnant?** Yes / No …. If you become pregnant, please notify our office before any procedure.

***Do you have any allergies?** Yes / No … If so, please list_____

***Do you smoke?** Yes / No … How many packs per day?_____

***Do you drink alcohol?** Yes / No … How much per day?_____

***How often do you tan? _____**

***Do you wear sunscreen every day? _____ *Do you burn easily when exposed to sun? _____**

Current Stress Factors (within the past / next 12 months)

- ☐ Death in the Family
- ☐ Divorce / Separation
- ☐ Marriage
- ☐ Job Change
- ☐ Financial Difficulties
- ☐ Children Moving Away
- ☐ Weight Gain / Loss (10 lbs)
- ☐ Pregnancy
- ☐ Nursing
- ☐ Major Health Issues
- ☐ No Current Stress

What treatments are you interested in?

- ☐ Abdominoplasty (tummy tuck)
- ☐ Arm lift
- ☐ Botox ®
- ☐ Breast augmentation / Breast lift / Breast reduction
- ☐ Buttocks lift / augmentation
- ☐ Cellulite
- ☐ Cheek augmentation
- ☐ Chemical Peel
- ☐ Chin augmentation
- ☐ Facelift/ One Hour Facelift
- ☐ Face contouring
- ☐ Hair restoration / Hair transplant
- ☐ Hand rejuvenation
- ☐ Jawline contouring
- ☐ Laser eyelid surgery
- ☐ Laser hair removal
- ☐ Laser skin resurfacing/ Coolaser / Fraxel
- ☐ Laser tattoo removal
- ☐ Laser vein removal
- ☐ Liposuction
- ☐ Lipofreeze
- ☐ Liquid face lift
- ☐ Lip augmentation / Lip lift
- ☐ Melasma
- ☐ Neck tightening / Neck bands / Neck lines
- ☐ One hour face lift
- ☐ Removal of brown marks /freckles / discolorations
- ☐ Removal of dark circles
- ☐ Rhinoplasty (non-surgical)
- ☐ Scar revision
- ☐ Skin care/Acne scar treatment
- ☐ Skin tightening
- ☐ Stretch mark removal / Coolbeam
- ☐ Ultrasound/ USRF
- ☐ Wrinkle reduction
- ☐ Other: _____

I acknowledge the following: I understand my initial appointment is with a consultant who may not be a medical doctor. The consultant's sole task is to provide basic information.

_____
Initial

HIPAA COMPLIANCE PLAN – PRIVACY RULE Epione Medical Corporation
PF -2000 Acknowledgement of Receipt of Notice of Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

I have received a copy of the Notice of Privacy Practices Epione Medical Corporation. _____
Initial

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. If the status of my health changes, I will notify the doctors at Epione Medical Corporation.

***Please bring your ID to the front desk.**

I hereby authorize Epione Medical Corporation to take and use pre-operative, intra-operative, and post-operative photographs, slides, and/or videos for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups. Every attempt will be made to conceal each patient's identity. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

OUR PRACTICE IS LIMITED TO COSMETIC MEDICINE ONLY, FOR GENERAL AND PATHOLOGICAL MEDICINE PLEASE CONTACT YOUR DOCTOR IN THESE RESPECTIVE FIELDS.

_____ _____

*Signature Date