O'NEIL SKIN AND LIPO MEDICAL CENTER
CONSULTATION FORM

To help us better meet your needs, please complete the form as thoroughly as possible.

PATIENT INFORMATION
(Please print clearly)

Date: ____/_____/____ Male Female

Patient Name: __________________________________
(Last Name, First Name)

Address:
____

City: ______________ State: ______ Zip: _______

Date of Birth: ___/___/___ Age:_____ Married Single

Occupation: Primary Language:

PHONE NUMBERS

Home Phone: (______) ________________________
Cell Phone: (______) ________________________
Business Phone: (______) ________________________
E-mail Address: ________________________________
Emergency Contact: ____________________________
Relationship: ___________________________________
Phone Number: (_____) __________________________

REFERRAL SOURCE

Whom can we thank for referring you to our office:
____

How did you here about us:
___Magazine (which Magazine_____________________)
___Internet ___Other _________________________
___Salon (which Salon_____________________________)
Did you attend a seminar? ___Yes ___No
If so, where? ___________________when? ___/___/20__

WHAT TYPE OF TREATMENT WOULD YOU LIKE TO DISCUSS

Non-Surgical FaceLift: _________
Complexion Peel: _______ Hands/Arms Peel: ________
Tumescent Liposculpture: _______ Smart Lipo: ________
Necklift: ______ Breast Augmentation: _______
Botox: ______ Coolsculpting: ______ VIPeel: ________
Radiesse:_____ Restylane:______ Juvederm/Voluma:_____

What cosmetic problems brought you to see Dr. O'Neil today? ____

What effect is this having on your daily life?
____

How long have you been seriously considering this treatment?
____ 1 month ____ 3 month ____ 6 month ____ other

How soon would you like to do this procedure?
____ 1 month ____ 3 month ____ 6 month ____ other

Is there anyone else that will help you with the decision making? ____ Yes ____ No If yes, what are their feelings?
____

Have you discussed this treatment with another physician? ____ Yes _____ No If yes, what type of procedure did he/she recommend?___________________________________

What other information do you need to make an informed decision? ____

DOCTOR'S NOTES:____
____
____
____
____

CONSULTATION/PROCEDURE SCHEDULING POLICY

A $50.00 consultation fee will be collected; this fee may be applied to my scheduled surgical procedure. I understand a 25% deposit is required for scheduling. This deposit is non-refundable if a cancellation occurs less than 21 days before treatment date. I also understand that if I choose to schedule a procedure on short notice, which is less than the 21 days from cancellation period, I will not be entitled to any refund. All cancellations must be in writing and returned certified mail, email or faxed to the office. Prices quoted are cash discounted fees. Rescheduling of surgery requires a minimum of 21 days notice before the date of procedure. Rescheduling in less than 21 days notice will result in a loss of your deposit and/or requirement of an additional deposit, both deposits of which are non-refundable upon any other schedule changes of procedure date. Dr. O'Neil quotes cash discounted prices, the balance will be due the day of the procedure and is to be paid in the form of a cashiers check or cash. If you choose to pay your balance with a credit card (Visa, MasterCard, Discover or American Express) the fee will be slightly higher – no personal checks will be accepted the day of treatment. Financing is available, information is available upon request. I have read and understood the Consultation/Procedure Scheduling Policy and have had the opportunity to ask questions if unclear.

Patient Signature: ____ Date: _________________
I have reviewed the cancellation policy and have received the privacy notice.

Office Signature: _______________________________________ Date: _______________ TIME: _________
I have addressed any questions asked by the patient named above.

Credit Card Authorization

I,____understand and agree to the charges placed on my credit card on__________________________in the amount of $____________________. This charge was applied with my authorization to secure the operating room and Dr. O'Neil's time for a procedure that I, or whom I am authorizing payment for, plan on having performed by Dr. Kelly O'Neil on ______________. I also understand and agree to the written cancellation policy that the O'Neil Skin & Lipo Medical Center has in effect, which states that no refunds will be made if cancellation is not made with a minimum of 21 days prior to my scheduled procedure date. The cancellation must be in writing and sent certified mail or faxed with verification that it was received by our office. I also understand and agree that if I choose to schedule a procedure on short notice, which is less than the 21 day cancellation period required, I will not be entitled to any refund. I also understand and agree that if I am purchasing any products from the office they are also non-refundable.

Name as it appears on credit card: ____

Credit Card Number: ____ Expiration Date: _______/_______

CVC:_______________

Credit Card Holder's Signature: ____________________________________ Date: ______/______/______

TIME :_________________________

MEDICAL HISTORY

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

AIDS/HIV	YES NO	HYPERTENSION	YES NO
ALLERGIES TO ANESTHETICS	YES NO	HITAL HERNIA	YES NO
ANEMIA	YES NO	KIDNEY	YES NO
ASTHMA	YES NO	KELOID SCARS	YES NO
BLEEDING DISORDERS	YES NO	LIVER	YES NO
DIABETES	YES NO	ORAL HERPES (FEVER BLISTERS)	YES NO
EPILEPSY	YES NO	SHORTNESS OF BREATH	YES NO
FAINTING/DIZZYNESS	YES NO	SIEZURES	YES NO
GENITAL HERPES	YES NO	SINUS OR STAPH INFECTIONS	YES NO
HEPATITIS A-B-C	YES NO	STROKE	YES NO
HEART DISEASE	YES NO		

DO YOU DRINK? ____YES ____NO HOW MUCH? ___________ DO YOU SMOKE? _____YES _____NO HOW MUCH? ____________
DO YOU USE RECREATIONAL DRUGS? _______ YES ______ NO

HEALTH CARE INFORMATION

ARE YOU A KAISER PATIENT? ____YES ____NO If yes, Kaiser Medical Record Number____

PRIMARY CARE PHYSICIAN'S NAME: ____

TELEPHONE NUMBER: _____________________________________ FAX NUMBER: _______________________________________

ADDRESS: ____ CITY: _________________________ STATE: ________ ZIP: ___________

PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS YOU HAVE HAD (INCLUDE COSMETIC):_________________________________

____

MEDICATIONS

ARE YOU ALLERGIC TO ANY MEDICATIONS? ______YES ______NO
IF YES, PLEASE LIST THE NAMES OF THE MEDICATIONS:
____
____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:
____
____

ARE YOU CURRENTLY ON BLOOD THINNERS? ______YES ______NO

ARE YOU CURRENTLY ON ASPIRIN THERAPY? ______YES ______NO

ALLERGIES

- ☐ ADHESIVE/TAPE
- ☐ ANTICOAGULANT THERAPY
- ☐ ASPIRIN
- ☐ CODEINE
- ☐ DEMEROL
- ☐ IODINE
- ☐ LATEX
- ☐ LOCAL ANESTHETICS
- ☐ NOVOCAINE
- ☐ PENICILLIN
- ☐ SULFA

OTHER: ____

BY SIGNING I HEREBY ACKNOWLEDGE THAT THE INFORMATION PROVIDED IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFROM DR. O'NEIL OF ANY HEALTH CHANGES.

PRINT PATIENT NAME: ____HEIGHT: ________________ WEIGHT: ________________

PATIENT SIGNATURE: ____DATE: ______________________TIME_________________