



Aesthetics and Facial Plastic Surgery

PATIENT INFORMATION

Please Print

Last name: _____ First name: _____ Middle initial: _____

Date of Birth: _____ Gender: Male Female Marital Status: M S W D

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Preferred method contact: (please check one of the following): _____

Address: _____ City/State: _____ Zip: _____

Occupation: _____ Employer: _____

Spouse or Contact person: _____

Drivers License number (if a minor, please use guarantor) Issuing State: _____ Number: _____

Did another physician **refer** you to Dr. Villano? YES NO Referring Physician: _____

Email: _____ May we email you monthly skin care special offers: Y N

Referred by: (please specify in the space provided)

Self _____
Newspaper _____
Magazine _____
Yellow Pages _____
Friend _____

Relative _____
Patient _____
Spa _____
Employee _____
Other _____

Reason for today's visit: _____

AUTHORIZATIONS

I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I authorize Cascade Faces to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Cascade Faces determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Cascade Faces.

I understand that I am responsible for any balance due for professional services in excess of the benefits provided by my policy. I agree to pay for services not covered by my insurance policy. I understand I am responsible for obtaining any prior authorizations required by my insurance policy. I understand that in the event of collection action, I am responsible for any legal fees incurred.

Signature: _____ Date: _____

PREVIOUS SURGERIES OR SERIOUS ILLNESSES

SURGERY	YEAR	SURGERY	YEAR
_____	_____	_____	_____
_____	_____	_____	_____



Aesthetics and Facial Plastic Surgery

CURRENT MEDICATIONS

(Include all over the counter and prescription drugs; including aspirin)

DRUG / DOSE	PRESCRIBED BY:	DRUG / DOSE	PRESCRIBED BY:
_____	_____	_____	_____
_____	_____	_____	_____

List any medications that you have had a bad reaction to: _____

PERSONAL INFORMATION

Height: _____ Current Weight: _____ Recent Weight Loss?: _____ If yes, how much? _____ lbs.

Do you smoke? YES NO How many? _____ Drink Alcohol? YES NO How much? _____

HISTORY

Have you had (Restylane, Collagen, etc.) injections? _____ Last injection? _____

Have you had Botox injections? _____ Last injection? _____

Have you ever been pregnant? YES NO How many times? _____ Live births? _____

Are you currently pregnant? YES NO Are you planning more children? YES NO

Have you used Acutane? _____ For how long? _____

Have you recently had facial surgery? _____ Type and date: _____

Have you ever had laser resurfacing? _____ Type and date: _____

Have you had a bad reaction to local or general anesthesia? YES NO If yes, explain _____

Have you had significant emotional problems? YES NO If yes, explain _____

Have you had psychiatric care? YES NO If yes, explain _____

Have you seen other plastic surgeons about this same problem? YES NO If yes, explain _____

Do you have high blood pressure? YES NO If yes, explain _____

Do you bleed easily from cuts or surgery? YES NO If yes, explain _____

Do you form large scars or keloids? YES NO If yes, explain _____

Do you have frequent infections or boils? YES NO If yes, explain _____

HAVE YOU HAD ANY SERIOUS ILLNESSES OF THE FOLLOWING? (Please circle)

Brain	Nose	Heart	Blood	Extremities	Eyes	Cancer
Ears	Lungs	Abdomen	Urinary	Nervous	Diabetes	Reproduction
Other						

Please explain, if you circled any of the above: _____

I hereby consent to be examined and treated by Michael E. Villano, MD and that the above information is correct.

SIGNATURE OF PATIENT OR SPOUSE OR RESPONSIBLE PARTY

DATE



Aesthetics and Facial Plastic Surgery

SKIN PROFILE

Date: _____
 Name: _____
 Date of Birth: _____ Height: _____ Weight: _____ Current Weight Loss? _____
 Do you wear contact lenses? _____

History

Are you currently pregnant or lactating? _____ Have you ever been pregnant? _____
 During pregnancy, did you experience hyper pigmentation? _____
 Areas: _____ Comments: _____

Do you currently have regular periods? _____
 Are you currently going through menopause? _____

Do you use tanning booths? Yes No If yes, when did you last tan? _____
 Do you currently have a sunburn or windburn? _____ Area: _____
 Do you currently have waxing / electrolysis treatments? _____ Area: _____
 Are you currently using Biore' or other acne strips? _____ Area: _____
 Are you currently using Retin-A, Renova or Differin? _____ Strength: _____
 Are you using glycolic / AHA home care products? Yes No If yes, please list: _____
 How frequently? _____ Area: _____ For how long? _____
 Are you currently using Acutane? _____ For how long? _____
 Are you currently having microdermabrasion? _____ For how long? _____

Do you have regular Restylane or Collagen injections? Yes No Last injection? _____
 Do you have regular Botox injections? _____ Last injection? _____

Do you participate in vigorous aerobic activity and how often? _____

Have you ever had a peel? _____ Date of last peel? _____
 Type of peel? _____ Describe your reaction? _____

Have you recently had facial surgery? _____ Type and date: _____
 Have you ever had laser resurfacing? _____ Type and date: _____

Do you smoke? _____ Packs per week and for how long: _____
 Do you develop cold sores or fever blisters? _____ Last breakout: _____

Are you allergic or sensitive to any of the following? Please check all that apply

_____ Milk	_____ Aloe	_____ Grapes
_____ Apples	_____ Perfumes	_____ Aspirin
_____ Citrus	_____ Latex	_____ Hydroquinone

Any other allergies? _____
 Are you sensitive to alcohol based products? _____
 Are you taking any medications at this time, over-the-counter or RX? _____

Skin Condition

Describe your skin from the following choices, please check all that apply.

Thick _____	Comedones _____	Eczema _____	Perfume-stained _____
Thin _____	Milia _____	Freckled _____	Hypo-Pigment _____
Saggy _____	Cystic _____	Sun-damaged _____	Hyper-Pigment _____
Firm _____	Breakouts _____	Uneven/Blotchy _____	Psoriasis _____
Normal _____	Scarred _____	Mature _____	Dehydrated _____
Dry _____	Large Pores _____	Wrinkled _____	Asphyxiated _____
Combination _____	Small Pores _____	Patchy Dryness _____	Capillaries _____
Oily _____	Florid _____	Sallow _____	
Acne Prone _____	Rosacea _____	Melasma _____	



Aesthetics and Facial Plastic Surgery

Which of the following do you consider your skin to be? Please check one of the following
Sensitive _____ Resilient _____ Not Sure _____

Eye color:
Blue _____ Green _____ Gray _____
Light Brown _____ Medium Brown _____ Dark Brown _____

Natural hair color:
Blonde _____ Red _____ Light Brown _____
Medium Brown _____ Dark Brown _____ Black _____
Gray/Silver _____

Skin tone:
Pale/ white _____ Light _____ Medium _____
Reddish _____ Freckled _____ Light Olive _____
Medium Olive _____ Dark Olive _____ Light Brown _____
Medium Brown _____ Dark Brown _____ Soft Black _____
Black _____ Sallow _____

What is your hereditary make-up? _____

Have you ever used any products that cause a bad reaction? _____
How does your skin react to them? _____

What is your daily home care regimen? _____

What are the cosmetic improvements you would like to see in your skin? _____

Photos taken today? _____ Areas: _____

Any comments: _____

Aesthetician Signature: _____ Date: _____



Aesthetics and Facial Plastic Surgery

AESTHETICIAN SERVICES FINANCIAL POLICY

Thank you for choosing Cascade Faces Aesthetics and Facial Plastic Surgery for your skin care needs. Our goal is to make your experience a pleasant one. For your convenience, and to avoid any future confusion, we would like to outline our policies and procedures for you.

CONSULTATION

A \$35 **cosmetic consultation** is scheduled from your initial telephone call. This consultation is designed for you and your aesthetician to meet and discuss your aesthetic needs, outline the procedure, and inform you of the fees.

PAYMENT

Payment is required at the time of treatment. If you elected a package of treatments, payment will be required at your first treatment.

CANCELLATIONS and NO SHOW

Cancellations within 2 business days of your scheduled appointment will be charged a cancellation fee of \$35.00. Failure to show up for your appointment will result in a "no show" fee of \$35.00.

If you have any questions, the staff will be happy to assist you. We look forward to caring for you.

Please sign and date.

Financial Guarantor Signature: _____ Date: _____

MICHAEL E. VILLANO, MD, LLC

Acknowledgment and Consent

I understand that _____

(Michael E. Villano, MD, LLC)

(referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
• refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
• determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
• perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient representative)
Description of Representative's Authority _____