THE GILL CENTER

FOR PLASTIC SURGERY & DERMATOLOGY

Today's Date: _____ /_____ /_____ Name:

_____

Address:_____

_____

City/State/
Zip:_____

_____

Home Phone: _____ Work Phone: _____ Cell Phone:
_____Carrier:_____

Email Address: _____ Preferred Contact: Cell Home Work

Date of Birth: _____ /_____ /_____ Age: _____ Gender: M F

Marital Status: _____Emergency Contact: _____ Phone Number:

_____

Relationship of Emergency Contact:

_____

Name of Parent or Guardian (if patient is a minor):

_____

Who may we thank for referring you to our office?:

Facebook	Google	Snapchat:
Instagram	Review IT Magazine	Realself.com
Physician:	Family or Friend:	Other:

The above information is true to the best of my knowledge. I understand that I am financially responsible for any charges for services provided.

Signature:

_____**Date:**_____

_____

MEDICAL HISTORY

Today's Date: _____ /_____ /_____ Name:

_____

Please list the reason for your consultation:

_____

Height: _____ Weight: _____ Age:

_____

Pharmacy Name and Phone Number:

_____

Medical History: (Please check)

Anxiety/Depression	Hepatitis
Arthritis	Hypertension
Artificial Joints	HIV/AIDS
Asthma	Hypercholesterolemia (High Cholesterol)
Atrial Fibrillation	Cancer (specify):
Benign Prostatic Hyperplasia	Blood clots
Seizures	Blood Transfusion
Diabetes	Anemia
Fainting spells	Heart surgery/stents
Thyroid disorder (specify)	Coronary Artery Disease
Lung Disease	Prostate Cancer
Acid Reflux	Irritable Bowel Disease (Crohn's or Ulcerative colitis)
Kidney disease/stents	Stroke
Hearing Loss	Valve replacement
Mitral valve prolapsed	Abnormal bleeding

Other:

_____

_____

Previous surgeries (including cosmetic surgeries and procedures):

_____

_____

Skin Disease History: (Please check & write):

Acne	Blistering sunburns
Rosacea	Atypical or irregular moles (nevi)
Skin cancer: Specify:	History of thick scars or keloids
Eczema	Psoriasis
Accutane use	

Do you wear sunscreen regularly? Yes No
If yes, what SPF:

_____

_____

Do you tan in a tanning salon? Yes No

Gynecology history (Please check, write in or circle)**:**

Name of current obstetrician/
gynecologist:_____

Are you currently pregnant, actively trying to get pregnant OR breastfeeding?

Yes No

Number of Pregnancies:_____ Did you breastfeed? Y N Total
Duration:_____

Last Menstrual Period: _____ Date of last mammogram, if
applicable:_____

Family medical history (Please circle and write in)**:**

Kidney disease: Y N	Heart Attack/disease: Y N	Abnormal bleeding: Y N
Tuberculosis: Y N	High Blood Pressure: Y N	Cancer: Y N
Diabetes: Y N	Anesthesia problems: Y N	Melanoma: Y N

Please describe all yes responses:_____

_____

_____

List all current Medications:

_____

_____

_____

_____

_____

Vitamins/Herbals:

_____

__

Regular aspirin use: Y N **NSAIDS/IBUPROFEN(Motrin, Advil etc):** Y N

Medication allergies (please circle & list all allergies):

Y N Name and Reaction:_____

Latex Allergy:

Y N Source and Reaction:_____

Tape Allergy:

Y N Type and Reaction:_____

Social History:

Patient's Employer:

_____

__ Occupation: _____ Full-Time Student? Yes No

Do you smoke cigarettes or vape? Yes No
If yes, how much?

_____

____

Do you drink alcohol? Yes No
If yes, how much?

_____

____

How often do you exercise?
Once a day
Few times weekly
Sometimes
Never

What is your caffeine use?
Several times a day
Once a day
Few times a week
Never

Optional: I would like to schedule a cosmetic consultation to discuss:

Cosmetic Services (with Dr. Anita Gill)

- CoolSculpting (fat reduction)
- Facial Skin Care & ColoreScience (makeup)
- Botox (wrinkle reduction)
- Fillers (add volume to face)
- Chemical peels
- Micropen (acne scars, fine lines)
- Kybella (double chin)
- Scar treatment
- Laser (photofacials, Fraxel, laser hair removal)
- Dermaplaning
- HydraFacial
- PRP or vampire facelift
- Earlobe repair
- Other: jowls, chin augmentation, facials, under eye circles, pores/texture, brown spots/melasma or

_____

Plastic/Cosmetic Surgery (with Dr. Paul Gill):

- CoolSculpting (fat reduction)
- Face/Neck Lift
- Mommy makeover (tummy tuck and breast surgery)
- Tummy tuck
- Extended tummy tuck
- Liposuction Area:_____
- Upper or lower eyelid surgery
- Breast Augmentation (saline or silicone implants)
- Breast Lift
- Breast Reduction
- Post-Weight loss body contouring (arms, abdomen, thighs)
- Buttock Lift/Body Lift
- Fat grafting buttocks (Lipo 360/BBL)
- Fat grafting hips

Patient Signature:_____**Date:**_____
_____

NOTICE OF PRIVACY AND HIPAA

Today's Date: _____ /_____ /_____ Name:
_____

You may be contacted by the practice to remind you of appointments, healthcare treatment options or other health services that may be of interest to you.

Leave a message on your preferred contact number regarding medical results? Yes No
Home Phone:_____ Mobile Phone:_____

Do we have permission to confirm your appointment via text? Yes No

Do you authorize emails pertaining to appointment reminders, specials, events, etc? Yes No

Do we have permission to discuss your medical condition with a family member? Yes No

If yes, who? _____ Relationship: _____ Telephone:
_____

I, _____, acknowledge that the Gill Center for Plastic Surgery & Dermatology has provided me with a copy of my privacy rights (also available on their website: www.drpaulgill.com as a patient covered under the HIPAA act. I have been given the opportunity to read this notice in its entirety; and ask questions about anything I do not understand regarding my rights as a patient.

I understand that this authorization allows my medical and billing information to be utilized in accordance with HIPAA standards for the purposes of treatment and billing for any services and products that I may receive under the care of the Gill Center for Plastic Surgery & Dermatology.

Signature: _____ **Date:** _____

FINANCIAL POLICY

the Gill Center for Plastic Surgery & Dermatology is committed to providing you with quality care. As a patient of Gill Plastic Surgery & Dermatology you are financially responsible for all medical and cosmetic services. Your clear understanding of our financial policy is important to our professional relationship. Our office will be pleased to discuss our professional fees with you at any time.

CANCELLATION POLICY: Our office works very diligently to schedule all appointments in a timely manner; therefore if you request to reschedule or cancel an appointment, we ask for at least 48 hours notice prior to your appointment date. the Gill Center for Plastic Surgery & Dermatology reserves the right to charge the patient a $100 fee if the patient does not cancel within 48 hours.

LATE POLICY: Our office is committed to maintaining a prompt schedule for all of our patients. If you are going to be more than 15 minutes late, please contact our office as you will be required to reschedule your appointment.

COSMETIC APPOINTMENTS: A deposit of $100.00 will be required to secure your cosmetic appointment. The deposit will be applied to your treatment cost. However, if you DO NOT cancel your appointment at least 48 hours before your scheduled appointment time; or you fail to show up for the visit, the deposit will not be refunded nor credited to a future appointment. We are more than happy to answer any questions you have regarding this policy. For cosmetic surgery, see under methods of payment for further information.

COSMETIC SURGERY REVISIONS: All revisions and/or "touch ups" surgeries are subject to hospital, anesthesia, and doctor's fees.

Please keep in mind, that you are not paying for a result, but you are paying for a service. Sometimes a better result involves more services or treatments. It is unethical for a medical provider to charge for an end result. We charge for a service. Although we may discount additional procedures or services, please do not expect or demand free services based on a previous purchase. This is not justified and not part of our office policy. We will make recommendations on what we feel is going to give you our best results and it is up to your judgment and budget on what services to proceed with.

PATHOLOGY/LABORATORY: Skin samples are sometimes sent to a laboratory for microscopic evaluation to determine or confirm proper diagnosis. I authorize and understand that I am responsible for the cost of any testing or lab services performed for me and that billing of such services may be billed independently by another physician or laboratory if my insurance does not pay or I am a self-pay patient. We will collect your insurance information because the laboratory accepts most major insurance carriers.

WAIVER FOR SKIN CARE PRODUCTS:

I understand that this product is medical grade skin care and will enhance my skin care regimen. The physician has explained to the patient/family/guardian the benefits of the skin care product to be reasonably expected compared with alternative approaches. Please note that we cannot accept returns on the product as per the medical company's policy. As with any new skin care, there is a small risk of skin allergic reaction; please notify if this occurs so we can alert the medical company and guide you on your treatment.

Patient Signature:_____**Date:**_____

METHODS OF PAYMENT:

Our office accepts cash, Debit, VISA, Discover, MasterCard and American Express. We gladly accept personal checks, CareCredit, prosper health care lending for cosmetic surgeries; however, we will only accept personal check payments 14 or more days before your surgery date. Otherwise, no checks are accepted. A $25.00 return check fee will apply to all returned checks. We do not accept postdated checks and will not hold checks.

When a cosmetic surgery is scheduled, a $500.00 deposit is required. The deposit is non-refundable, but it applied to your balance. Full payment is required at the time of the pre-op appointment or 14 days prior to surgery. If you reschedule your surgery, a $500 service fee will be charged.

Note that if you cancel your surgery within 2 weeks of your scheduled surgery date, 50% of your surgeon fee will be deducted before a refund is given.

During "peak" seasons such as Spring Break, Winter Break and Thanksgiving break, a 20% deposit is required to book surgery. This deposit is applied to your balance.

• I have read the Financial Policy for the Gill Center for Plastic Surgery & Dermatology

• I understand that I am personally responsible for payment on my account

Signature: _____ **Date:** _____

Printed Name:

_____