MEDILASER

COSMETIC SURGERY AND VEIN CENTER

3110 W. Main Street, Suite 150 Frisco, Texas 75033
Ph: 469-362-8665 Fax: 469-362-8085

QUESTIONNAIRE

Name_____ Date____/____/____

CHECK THE SERVICES YOU ARE INTERESTED IN

- ☐ **NEUROMODULATORS**
  - ☐ BOTOX® ☐ DYSPORT® ☐ XEOMIN®
- ☐ **DERMAL FILLERS**
  - ☐ JUVÉDERM® ☐ Restylane® ☐ RADIESSE® ☐ Sculptra® ☐ BELOTERO® ☐ VOLUMA®
- ☐ **LIPOSUCTION**
  - ☐ Abdomen ☐ Flanks ☐ Arms ☐ Back ☐ Neck ☐ Thighs
- ☐ **BELLY BUTTON REPAIR**
- ☐ **EAR LOBE REPAIR**
- ☐ **KYBELLA**
- ☐ **SKIN PLASTY**
  - ☐ Tummy Tuck ☐ Neck Lift ☐ Arm Lift ☐ Thigh Lift
- ☐ **FAT TRANSFER**
  - ☐ Brazilian Butt Lift ☐ Natural Breast Augmentation ☐ Face Rejuvenation
  - ☐ Hands Rejuvenation ☐ Neck Rejuvenation ☐ Vagina Rejuvenation
- ☐ **VARICOSE VEIN TREATMENT**
  - ☐ Vein Removal ☐ Vein Ablation ☐ Injection Therapy ☐ Laser Vein Removal
- ☐ **LASER TREATMENTS**
  - ☐ Permanent Hair Reduction ☐ Ablative Skin Rejuvenation ☐ MicroLaser Peel
  - ☐ Sun/Age or Brown Spots ☐ Rosacea Reduction ☐ BBL/Photofacial
  - ☐ Acne Treatments ☐ Stretch Marks ☐ Pore Reduction
  - ☐ Skin/Wrinkle Tightening ☐ Scar Reduction
  - ☐ Vein Removal ☐ Other_____
- ☐ **CHEMICAL PEEL**
- ☐ **BREAST AUGMENTATION**
- ☐ **NIPPLE INVERSION REPAIR**
- ☐ **VAGINAL REJUVENATION**
- ☐ **LIP IMPLANTS**
- ☐ **SILHOUETTE LIFT**
- ☐ **SKINCARE PRODUCTS**
  - ☐ Giraldo MD ☐ Silagen Scar Treatment ☐ EltaMD ☐ glō•minerals ☐ Obagi ☐ SkinCeuticals ☐ Revitalash
- ☐ **TEETH WHITENING**
- ☐ **OTHER**_____

How did you hear about our office?

- ☐ Our Webpage ☐ Internet ☐ Yelp ☐ Facebook ☐ Brochure ☐ Walk-By
- ☐ Doctor_____ ☐ Friend_____
- ☐ Other_____

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REGISTRATION

Last Name_____ First Name_____ MI____ DOB____/____/____

Age____ Sex ⬭ M ⬭ F Marital Status ⬭ Married ⬭ Single ⬭ Separated ⬭ Divorced ⬭ Widowed

E-Mail_____

☐ By checking this box, I am agreeing to correspond via e-mail/ text messaging with Medilaser regarding my clinical records/reports/appointments

Address_____ City_____ State____ Zip Code_____

Home Phone____-____-____ Cell Phone____-____-____ Primary ⬭ Home ⬭ Cell

Who referred you to our office?_____

Pharmacy_____ Address_____ Phone____-____-____

EMERGENCY CONTACT

Name_____ Relationship_____ Phone____-____-____

PRIMARY INSURANCE CARRIER

Insurance Name_____ Insurance Phone____-____-____ Copay $____

Insurance Address_____ City_____ State____ Zip Code_____

Member ID#_____ Group #_____

Member Name_____ DOB____/____/____ Phone____-____-____

Member Address_____ City_____ State____ Zip Code_____

Relationship to Insured ⬭ Self ⬭ Spouse ⬭ Child Referral Needed ⬭ Yes ⬭ No

SECONDARY INSURANCE CARRIER

Insurance Name_____ Insurance Phone____-____-____ Copay $____

Insurance Address_____ City_____ State____ Zip Code_____

Member ID#_____ Group #_____

Member Name_____ DOB____/____/____ Phone____-____-____

Member Address_____ City_____ State____ Zip Code_____

Relationship to Insured ⬭ Self ⬭ Spouse ⬭ Child Referral Needed ⬭ Yes ⬭ No

"I hereby authorize payment directly to Mauricio Giraldo, MD of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance for services rendered on my behalf or my dependents. I authorize the above provider to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I hereby grant permission to Mauricio Giraldo, MD to employ such medical, surgical, and x-ray procedures as my doctor may consider necessary in my diagnosis and treatment.

Signature of patient (Parent if patient is a minor)_____ Date____/____/____

"I authorize the release of medical information pertaining to my health to Medilaser, Cosmetic Surgery and Vein Center."

Signature of patient_____ Date____/____/____

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MEDICAL REVIEW

Name_____DOB____/____/____Date____/____/____Height_____

GENERAL
- Fever
- Lack of energy
- Weight Loss
- Weight Gain
- Other

_____

HEAD, EYES, EARS, NOSE, & THROAT
- Headaches
- Sinus problems
- Nosebleeds
- Hearing loss
- Hoarseness
- Glaucoma
- Cataracts
- Other

_____

MUSCULAR -SKELETAL
- Joint pain
- Bone pain
- Muscle pain
- Swelling
- Other

_____

RESPIRATORY
- Shortness of breath:
  - at rest
  - during activity
  - at night
- Wheezing
- Cough
- Other

_____

DIGESTIVE
- Heartburn
- Pain in stomach
- Difficulty swallowing
- Nausea
- Diarrhea
- Constipation
- Bloody stools
- Black stools
- Other

_____

HEMATOLOGIC
- Unusual bleeding
- Unusual bruising
- Anemia
- Other

_____

CARDIOVASCULAR
- Chest pain
- Palpitations
- Other

_____

NEUROLOGIC
- Seizures
- Blackouts
- Other

_____

GENITO-URINARY
- Painful urination
- Other

_____

SKIN
- Itching
- Rash
- Other

_____

PSYCHIATRIC
- Depression
- Anxiety
- Other

_____

Do you use: Alcohol □YES □NO Tobacco □YES □NO Recreational Drugs □YES □NO

List current medications – include over-the counter medications and vitamins:
List allergies to medications/tape/food/environmental:
List previous surgeries:
List medical conditions:
List history of family medical conditions:
What type of work do you do?

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ACKNOWLEDGEMENT OF REVIEW OF "NOTICE OF PRIVACY PRACTICES"

I, _____, have reviewed the "Notice of Privacy Practices" which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature_____ Date____/____/____