COLE
FACIAL CLINIC

Patient Information

Date: _____

First Name _____ Middle Initial_____ Last Name_____

Address _____ City _____ State_____ Zip _____

Social Security # _____/_____/_____ **Birthdate** _____/_____/_____ **Age**_____

Gender M____F____ Marital Status S____M____ Other_____

Home Phone _____ Work Phone _____ Ext._____

Cell _____**E-mail**_____

*By providing my email address and cell phone I give you permission to send me electronic appointment reminders, patient information, newsletters and promotional emails/text messages about specials and events. I understand that I may unsubscribe at any time, and that you will never sell or share my email with any external entity. *Check here if you do **not** wish to receive specials and events emails* or text messages [ ]

EMERGENCY CONTACT INFORMATION

First Last Name_____Relationship_____

Phone: _____

***If this is an Insurance Visit please provide our office with a copy of the Insurance Card and Driver License**

If patient is a minor, please complete this section:

Name: _____Phone: _____Relationship to Patient_____

Reason for Visit Today: _____

What are your problem areas? Please mark all areas of the face that you are unhappy with:

Forehead	**Upper eyes**
Lower eyes	**Cheek area**
Nose	**Mouth**
Jawline	**Neck**
Other:	

What brings you to our clinic? Please mark what services you are interested in:

Fine lines	**Wrinkles**
Volume loss	**Tired Eyes**
Volume loss in Lips	**Drooping Eye Lids**
Scars	**Other**

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PATIENT HISTORY

PLEASE CHECK IF YOU HAVE HAD ANY OF THE HEALTH PROBLEMS LISTED BELOW: (PAST HISTORY)

Heart Attack	Chest Pain	Diabetes	Hearing Loss
Asthma	AIDS/HIV+	Bleeding Disorder	Down's Syndrome
Arthritis	Ulcers	Migraines	Keloid or ugly scars
Cystic	Fibrosis	Heart Murmur	Seizures
Sinus Disease	Hiatal hernia	Emphysema	Stroke
Hypoglycemia	Glaucoma	Anemia	Hepatitis
Kidney Infections	Phlebitis	Heart Disease	Meningitis
Pneumonia	Nose Bleeds	Tuberculosis	High Blood Pressure
Thyroid Problems	Cancer	Head injury	Jaundice
Back Problems	Kidney Disease	Liver Disease	Other:

PLEASE CHECK IF ANY BLOOD RELATIVES HAVE HAD ANY PROBLEMS LISTED BELOW: (FAMILY HISTORY)

Heart Disease	Tuberculosis	Ulcers	Chronic Middle Ear Infections
High Blood Pressure	Hepatitis	Asthma	Anesthesia Problems
Hearing Loss	Cancer	Bleeding Disorders	Stroke
Diabetes	Allergies	Other:	

- **LIST PAST SURGERIES:** _____
- **Do you have food or environmental allergies? (If so, please list)** _____
- **Do you have any allergies to medications, topical creams or ointments? (If so, please list)** _____
- **Please list all medications you are currently taking: (please include vitamins or herbal supplements?** _____

Preferred Pharamcy:_____

Authorization and assignment of benefits (Please sign All)

I authorize Dr. Jeptha Cole M.D. To give information pertaining to my current illness and treatments to my insurance carriers.

Signature _____ **Date** _____

I assign to Dr. Jeptha Cole M.C. all payments for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by my assigned insurance.

Signature _____ **Date** _____

I have received a copy of Cole Facial Plastic Surgery's Notice of Privacy Practices, and the Patient Rights and Responsibilities.

Signature _____ **Date** _____

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I hereby give my permission to Dr. Jeptha Cole M.D. or any assistant that he may designate, to take photographs for diagnostic purposes, to enhance the medical report, during surgery, and postoperative for evaluation purposes. I agree that these photographs will remain his property.

Signature _____Date _____

PHOTOGRAPHY CONSENT (*ASK ABOUT SPECIAL CONSIDERATION FOR ALLOWING US TO USE YOUR PHOTOS)

Payment is due when services are rendered. Itemized receipts are available upon request.

NO- SHOW POLICY: Any patient who no-shows to their appointment will be charged a no-show fee of $100.00 and this must be paid to the clinic before the patient can schedule another appointment.

- **Have you ever had a reaction to anesthesia? Yes or No**
- **Do you smoke? Yes or No, if so how much? _____ For the last _____ years**
- **Are you on any supplements like SeroVital?_____**
- **How do you sleep at night?**
  _____
- **Do you ever get cold sores or fever blisters? Yes or No**
- **Do you use Retin A or a Retinol product? Yes or No**
- **Do you drink alcohol? Yes or No, how many drinks _____ per week, _____ per month**
- **Are you a past/ present carrier of a contagious disease? Yes or No _____**
- **Do you bruise easily? Yes or No**
- **Have you ever used Accutane? Yes or No (if so, when?) _____**
- **What type of skin care products are you currently using?**
  _____
- **Have you ever had a chemical peel? Yes or No**
- **Do you get regular facials? Yes or No**
- **Do you use sunblock? Yes or No**
- **Have you ever had injections (Botox, Dysport, Collagen or Fillers)? Yes or No**
- **If Yes, what was the date of the injection and what type of injection was it? _____**

How did you hear about us?

Facebook Instagram Google Yelp Ms Magazine Other:_____

Friend/Patient: (may we thank them?)_____