POPE Plastic Surgery

ASPS Member Surgeon

Patient Information

Name (last, first middle):_____Date of Birth: _____

Gender:_____Age:_____Height/Weight:_____

Address: _____

Number: _____Email Address: _____

Parent or Spouse Information

Name:_____Contact Number: _____

Referral Information

What is the reason for today's visit?_____

Have you been seen/treated elsewhere? ☐ Yes ☐ No If so, by whom?_____

Referral Information

How did you hear about us? (please check more than one if applicable)

☐ Referred by: May we thank them? ☐ Yes ☐ No

☐ Internet ☐ Word of mouth

☐ Billboard, location?_____ Magazine, which one? _____

☐ Other, please explain: _____

Primary Care Physician

Name: _____Number:_____

Address:_____

Emergency Contact

Name: _____Relationship: _____Number:_____

Communication Use & Disclosure Authorization

You may leave a voicemail and/or send an email regarding:

☐ Appointment Information ☐ Brilliant Distinctions ☐ Prescription/refill info

☐ Referral information ☐ Test results ☐ Other

You may discuss information and care with the following family member(s) and/or friends:

_____

Please contact me regarding my treatment and care at the following number(s):

_____

Personal Medical History: ☐ NONE

☐ Abdominal bleeding
☐ Asthma
☐ Breast cancer
☐ Cancer
☐ Chest pain
☐ Chemo/radiation
☐ Diabetes
☐ Heart disease
☐ Heart murmur
☐ Hepatitis
☐ High blood pressure
☐ HIV
☐ Kidney Problems
☐ Skin cancer
☐ Stroke
☐ Thyroid disorder
☐ Tuberculosis (TB)
☐ Eye trouble
☐ Blood clots/bleeding disorders
☐ MRSA,
☐ Neurological disease
☐ Malignant hyperthermia
☐ Psychiatric condition
☐ (anxiety, depression, etc.)
☐ Other:

Please explain any of your selections above:

Family Medical History: ☐ NONE ☐ Unknown/Adopted

	Family Member(s)	Explanation
☐ Breast cancer		
☐ Other cancer		
☐ Diabetes		
☐ Heart disease		
☐ High blood pressure		
☐ Bleeding disorder/clots		
☐ Obesity		
☐ BRCA positive		
☐ Other		

Surgeries / Hospitalizations ☐ NONE

Event, Year, Complication (yes/no):

Allergies ☐ NONE

Medication(s): Reaction

Food(s): Reaction

Smoking Status ☐ N/A ☐ Former Smoker (quit date):

☐ Current Smoker / Frequency: cigarette per ☐ day ☐ week

Type of Nicotine: ☐ Cigarettes ☐ E-cigarettes ☐ Vaping ☐ Oral/chewing

Alcohol Consumption ☐ No ☐ Yes Daily Amount

Recreational Drug Use ☐ No ☐ Yes Type/Amount

Acknowledgement of Receipt of Privacy Practices

The undersigned patient or legally authorized representative (agent) of the patient, acknowledges that he or she was personally offered and/or received a copy of POPE Plastic Surgery's Notice of Privacy Practices.

Signature of Patient or Guardian Date

Office Policies

Fees: I understand I am responsible for all fees and services provided by Dr. Pope and his staff. I agree to pay for all services.

Cancellation Policy for Injectable & Skincare Treatments: We take pride in providing service to our patients in a timely manner. Our priority is to schedule injectable and skincare treatments that best fit your schedule. We understand that occasionally plans have to be changed. Because there are many "moving parts" associated with running our practice efficiently, a change/ cancellation policy is necessary.

Policy for New Consultations and Injectables:

- $100 will be collected at the time of scheduling your consultation to secure your appointment. This will be applied to your surgery If you choose to move forward within the year.
- $100 will be collected at the time of scheduling your injectable appointment to secure your
- appointment. This will be applied to your scheduled procedure.
- Payment (in full) for Sculptra will be collected at the time of scheduling.
- Cancellation within 24 hours of scheduled appointment, cancellation or simply not showing on the day of the appointment, will result in forfeiture the $100 scheduling fee.

Policy for Skincare Treatments:

- $100 will be collected at the time of scheduling your skincare treatment appointment to secure your appointment. This will be applied to your scheduled procedure.
- Cancellation or rescheduling within 24 hours of scheduled appointment, cancellation or simply not showing on the day of the appointment, will result in forfeiture the $100 scheduling fee.
- Cancellation/ rescheduling of treatments on prepaid packages will result in a debit of $100 from the series, if appointment is prior to 24 hours.
- All balances must be paid prior to scheduling any future appointments.
- Thank you for your cooperation and understanding in this matter.

By signing below, I am acknowledging that I have read, understand, and accept the above policies.

Signature of Patient or Guardian Date

Submit