COSMETIC INTEREST QUESTIONNAIRE

Patient Name: _____ Date: _____

Procedures or Products of interest to you (please check all that apply).

- Botox ® or Xeomin Cosmetic
- Chemical Peels
- Skin rejuvenation
- Fine Lines: Retin- A
- Microlaser Peel
- Reduction of Acne Scars
- Spider Vein Treatment: Face or Legs
- Scar Improvement
- Cosmetic Fillers: Jevederm, Radiesse & Belotero
- Skin Care Products
- Birthmarks
- Liver Spots/Age Spots/Sun Spots
- Sunscreen Advice
- Hair Removal
- Wrinkle Improvement
- Skin Discoloration
- Excessive Sweating of the Underarms, Palms of Hands and/or Sole of Feet

Please answer the flowing questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older then my true age.

Younger Than		**True Age**		**Older Than**
1	**2**	**3**	**4**	**5**

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		**Somewhat Concerned**		**Very Concerned**
1	**2**	**3**	**4**	**5**

How did you hear about us?

- My physician (**first and last name**) _____
- My insurance company provider (name) _____
- A friend or family member (name) _____
- Internet

Thank You Very Much!
Solomon Brickman, MD

Dermatology Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If **YES**, list below:

1._____ 2._____

Have you ever had dental anesthesia (Novocain)? YES NO Any bad reaction? YES NO

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1._____ 3. _____ 5. _____

2. _____4. _____ 6. _____

Do you have now, or ever had diseases or conditions of: (Please circle YES or NO)

Lungs:			**Other Systemic:**		
Bronchitis	Yes	No	Diabetes	Yes	No
Emphysema	Yes	No	Excessive thirst/hunger	Yes	No
Asthma	Yes	No	Amputation	Yes	No
Chronic Cough	Yes	No	Thyroid	Yes	No
Morning Cough	Yes	No	Kidney	Yes	No
Shortness of Breath	Yes	No	Dialysis	Yes	No
Wheezing	Yes	No	Bladder	Yes	No
Cardiovascular:			Frequency/burning	Yes	No
High Blood Pressure	Yes	No	Gastrointestinal Stomach absorptive disorder	Yes	No
Chest Pain	Yes	No	Nausea, Vomiting, Diarrhea when taking antibiotics	Yes	No
Heart Attack	Yes	No	Yeast infection when taking antibiotics	Yes	No
Heart Murmur	Yes	No	Arthritis/Joint Deformity	Yes	No
Irregular Heartbeat	Yes	No	Arthralgia	Yes	No
Phlebitis	Yes	No	Limited Motion	Yes	No
Inflammation of Vein	Yes	No	**Artificial joint**	Yes	No
Blood clots	Yes	No	Convulsions, Epilepsy or Seizures	Yes	No
Pacemaker	Yes	No	Fainting	Yes	No

List any other diseases or conditions: _____

List surgical procedures you have had in the **last 6 months**: _____

Skin:

Have you ever had skin cancer? Yes No If yes, _____

Has anyone in your family had skin cancer? Yes No If yes, _____

Do you have a history of any specific skin disease? Yes No If yes, _____

Do you have problems with healing? Yes No

Do you develop keloids (scars) after surgery? Yes No

Do you bleed easily? Yes No

Do you develop skin rashes in reaction to medications, food, environment, bandages, topical Neosporin? Yes No

Social History:

Do you drink alcohol? Yes No If **YES**, _____ drinks per day week month year

Do you use IV drugs? Yes No If **YES**, What? _____ How often? _____

Do you smoke? Yes No if **YES**, how much per day: _____

Have you had or have been exposed to HIV (AIDS)? Yes No

Please answer the following questions;

(Women) Are you Pregnant? Yes No Due date: _____

What is your occupation? _____ Hobbies? _____

Completed by (circle one): Patient Medical Assistant _____ _____ _____

Initials Signed by Patient Date

PATIENT NAME: _____ DATE: _____

HAS THERE BEEN ANY ONE IN YOUR FAMILY WITH THE FOLLOWING DISEASES?
INCLUDE GRANDPARENTS, PARENTS, SIBLINGS, AUNTS, UNCLES, AND COUSINS.

DIABETES	YES	NO	IF YES, WHOM _____
STROKE	YES	NO	IF YES, WHOM _____
HEART TROUBLE	YES	NO	IF YES, WHOM _____
TUBERCLUOSIS	YES	NO	IF YES, WHOM _____
CANCER	YES	NO	IF YES, WHOM _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF THE ORGINIAL.

DATE: _____ SIGNATURE: _____

I HEREEBY AUTHORIZE SOLOMON S. BRICKMAN, MD. TO APPLY BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY HIM OR BY HIS ORDER. I REQUEST THAT PAYMENT FROM MY INSURANCE CAMPANY BE MADE DIRECTLY TO DR. SOLOMON S. BRICKMAN.

DATE: _____ SIGNATURE: _____

I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORGINAL. THIS AUTHORIZATION MAYBE REVOKED BY EITHER ME OR MY INSURANCE COMPANY AT ANY TIME IN WRITING.

DATE: _____ SIGNATURE: _____

IF MY INSURANCE COMPANY CONSIDER A PROCEDURE, TEST, OR VISIT TO BE COSMETIC IN NATURE, OR REFUSES TO PAY FOR THE PROCEDURE OR VISIT, I UNDERSTAND THAT I THEREBY BECOME RESPONSIBLE FOR THE CHARGES.

DATE: _____ SIGNATURE: _____

HOUSTON LASER SKIN CENTER

Solomon S. Brickman MD, FRCP (C)

11730 FM 1960 West

Houston, TX 77065

Phone: (281) 955-2263 Fax: (281) 955-7990

WWW.HOUSTONLASERS.COM

Consent for Communication of Protected Health Information

I, _____, GIVE MY CONSENT TO DR. SOLOMON S. BRICKMAN TO RELEASE PROTECTED HEALTH INFORMATION TO THE PEOPLE LISTED BELOW. THIS IS TO INCLUDE ANY RESULTS OF LAB, INCLUDING HIV TESTING, DIAGNOSTIC TESTING, OR MY MEDICAL CONDITION.

	NAME	RELATIONSHIP	DATE OF BIRTH
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

OR,

_____, IF NO OTHER PERSON
INTIAL

_____ _____

NAME OF PATIENT (PRINT) DATE OF BIRTH

_____ _____

SIGNATURE OF PATIENT DATE

HOUSTON LASER SKIN CENTER HAS NOTIFIED ME THAT THEY HAVE A PRIVACY POLICY AND A COPY OF THIS POLICY IS ABAILABLE TO ME UPON REQUEST.

_____ _____

PATIENT/ GUARDIAN SIGNATURE DATE

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Patient Media Release Form

I _____, hereby authorize Houston Laser Skin Center, Solomon Brickman MD or any of their assignees to take photographs, slides, and videos of myself.

I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (medical journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc.).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (initials only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

The **Health Insurance Portability and Accountability Act** still remains in place and I have been informed that absolutely no medical information will be released with the signing of this form.

Now, we do acknowledge that any patients that are under 18 years of age may not sign this without their parent present or parent's permission. If you are a parent signing for your child please enter their name in the space provided below.

If I wish to revoke this consent, I may do so in writing.

☐ **If declining this consent, please check this box**

Patient's Name: _____

Patient or Guardian Signature: _____Date_____

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No Show/Cancellation Notice

With appointment availability in high demand, a No Show fee of $45 will be billed to you if you don't provide at least 24 hour notice prior to cancellation or rescheduling your appointment. To avoid fee, if you reach us after hours, please leave a detailed message and we'll return your call as soon as possible.

Sincerely,

Dr. Brickman and Staff

Patient's Name: _____

Patient or Guardian Signature: _____Date_____

SOLOMON S. BRICKMAN, M.D., P.A., F.R.C.P (C)

PATIENT INFORMATION

PATIENT: _____DATE:_____
(FIRST) (MIDDLE) (LAST)

DOB: _____ SOCIAL SECURITY: _____ SEX: (M) OR (F)

(SINGLE) (MARRIED) (WIDOWED) (DIVORCED)

ADDRESS: _____APT_____

CITY:_____STATE:_____ ZIP: _____

BEST CONTACT NUMBER: _____E MAIL: _____

OCCUPATION: _____ EMPLOYER: _____

SPOUSE NAME: _____ CELL PHONE: _____

(PLEASE DO NOT LIST THE ABOVE CONTACT NUMBER LISTED FOR THE PATIENT)

EMERGENCY CONTACT: _____ PHONE: _____

WHO REFERRED YOU TO DR BRICKMAN_____
(FIRST AND LAST NAME OF REFERRING PROVIDERS)

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

POLICY HOLDER NAME: _____ DOB: _____

RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____

SOCIAL SECURITY NUMBER OF POLICY HOLDER: _____

OUR OFFICE DOES NOT FILE WITH ANY SECONDARY INSURANCE.

PHARMACY INFORMATION

PHARMACY NAME: _____

PHARMACY NUMBER: _____