MEDILASER

COSMETIC SURGERY AND VEIN CENTER

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

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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PHOTOGRAPHIC RELEASE AND CONSENT

Please INITIAL each that you agree to:

Initials________ I authorize Dr. Giraldo to use *my photographs, video tapes, and case information* **for medical documentation**.

Initials_______ I authorize Dr. Giraldo to use *my photographs, video tapes, and case information* **for medical consultation and release to my insurance company if necessary**.

Initials_______ I authorize Dr. Giraldo to use *my photographs, video tapes, and case information* in **educational and scientific settings**, including lectures and multimedia presentations for an audience of medical professionals, at which members of the press may be present, and medical, surgical, and scientific journal articles.

Initials_______ I authorize Dr. Giraldo to use *my photographs, video tapes, and case information* for **educational settings**, including my surgeon's office, patient education materials, and file of pre- and postoperative patient photographs available to prospective patients for viewing at the office.

Initials_______ I authorize Dr. Giraldo to use *my photographs, video tapes, and case information* (**without identification except views of the face**) in **commercial, educational settings**, including: lectures and multimedia presentations, newspaper and magazine articles, my surgeon's web site, radio & television programs, given by my surgeon for the general public.

Patient Signature______________________________ Date_____/_____/_____

Print Name______________________________

Witness______________________________ Date_____/_____/_____

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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______/_____/______

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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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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 ☐ Medilaser Email Newsletter ☐ Facebook ☐ Twitter ☐ Instagram ☐ Yelp ☐ Internet ☐ Brochure
☐ Walk-By ☐ Doctor____________________ ☐ Friend____________________ ☐ Other____________________