Aesthetic Surgery Center
500 Sutter Street, Suite 430
San Francisco, CA 94102
www.DrMMacdonald.com

Michael R Macdonald, MD, FACS, FRCSC
AESTHETIC SURGERY CENTER
You…Only Better

Patient Information Form

Patient Name: ______________________________ Today's Date: ____________________

Address: ____________________________ City: __________________ State: _______ Zip: ______________

Home Phone: __________________ Cell Phone: ______________________ Cell Phone Carrier: __________________

DOB: ______________________ Age: _________ Gender: _____________ Marital Status: ____________________

Social Security Number: ___________________________ Email Address: _________________________________

Employer Name: _________________________________ Address: _______________________________________

Occupation: _____________________________________ Work Phone: ____________________________________

Who is your primary care physician? ____

How did you hear about our clinic?

- ☐ DrMMacdonald.com
- ☐ SanFranciscoSnoring.com
- ☐ RealSelf
- ☐ Google
- ☐ Patient Referral: ______________
- ☐ Other: ____
- ☐ Facebook
- ☐ Twitter
- ☐ Yelp
- ☐ Yellow Pages (city): ____________
- ☐ Friend / Family: ________________
- ☐ Dr. Referral: __________________
- ☐ Seminar: ______________________
- ☐ La Belle Spa: _________________
- ☐ Beauty Network: ______________
- ☐ Original Skin: _________________

What is the nature of your visit?

SURGICAL		LASER/SKIN CARE	
☐ Eyelid Surgery	☐ Brow lift	☐ Facial Rejuvenation	☐ Wrinkles
☐ Facelift	☐ Mid-face Lift	☐ Red Spots	☐ Age Spots/brown spots
☐ Cheek/Chin Implant	☐ Liposuction	☐ Facial Veins	☐ Chemical Peels
☐ Nasal Surgery	☐ Otoplasty	☐ Skin Resurfacing	☐ Leg Veins
☐ Mole removal	☐ Excision & Scars	☐ Skin Tightening	☐ Medical grade products
INJECTABLES/FILLERS		**SNORING TREATMENT**	
☐ Botox / Dysport	☐ Restylane / Perlane	☐ Snoring Treatment	
☐ Juvederm/Voluma	☐ Radiesse	☐ Obstructive Sleep Apnea Treatment	

SUPPLEMENTS		
☐ Anti-Aging	☐ Weight Loss	☐ Performance Enhancing

Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

____

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Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

____

____

2. Have you or a blood relative had complications with anesthesia? ☐ No ☐ Yes, please describe:

____

____

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes ☐ Maybe/trying   Height: ____________ Weight: ____________

		No	Yes	Description
2.	Asthma or Lung Disease	☐	☐	
3.	Migraine Headaches	☐	☐	
4.	High Blood Pressure	☐	☐	
5.	Heart Trouble	☐	☐	
6.	Hepatitis or Liver Trouble	☐	☐	
7.	Kidney Disease	☐	☐	
8.	Diabetes	☐	☐	
9.	Problem Scarring	☐	☐	

10. **Other medical problem(s) that we should know about**: ______________________________

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? ____________
2. Do you drink? ☐ No ☐ Yes, how much? ____________
3. Do you have children? ☐ No ☐ Yes, how many? ____________

Section IV: Family History

Please list any significant or relevant family medical problems:

____

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Section V: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:
____

Emergency Contact

Name: ______________________ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: __________

Home Phone: _______________ Cell Phone: ________________ Work Phone: _______________

Insurance Information

If applicable, please state the name of your insurance company: ______________________________
(Health information is released to your insurance company with your permission only)

Financial Policy/Cancellation Policy

CANCELLATIONS: Please be advised that we have a cancellation fee of **$100** for missed appointments or cancellations not received 48 hours prior to your appointment. We understand that emergencies do arise; however we request at least 48 hour notice for rescheduling or canceling all appointments. Failure to do so may result in your account being charged. Informing us of your cancellation allows us to fill your reserved time. **NO SHOWS WILL BE BILLED THE CANCELLATION FEE.**

Treatments: All treatments, procedures or pre-paid packages are non-refundable. Packages must be used within one year from the date of purchase. Credit from pre-paid treatments, procedures and/or packages may be applied toward other forms of treatment(s) or product(s) only at management's discretion. Credit can only be given to and used by purchaser. **NO REFUNDS. EXCHANGES ONLY.**

Appointments: We recommend that you make your next appointment prior to leaving our office. This is particularly important if you are having a series of treatments over a defined period of time.

Arrivals: Please arrive for your appointment in our office on time. This ensures that you will receive the required amount of time you deserve for your treatment and helps us to not intrude on the following patient's reserved time.

I have read this questionnaire, I understand the cancellation policy and I have disclosed my medical history to the best of my knowledge.

Patient Signature: ____________________________________ Date: _________________

Receipt of Notice of Privacy Practices (also available at www.DrMMacdonald.com)

I have received a copy of Aesthetic Surgery Center's Notice of Privacy Practices.

Patient Signature: ______________________________ Date: _________________

Patient Name ____________________________

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Consent to Communicate

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders				
☐ Email Medical Info				
☐ Email Marketing Info				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Page	-	-	☐	-
☐ Text Appt Reminders – if so, list cell carrier:				
☐ Text Marketing Info – if so, list cell carrier:				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: ____ Date: ____________________

Patient Name ____________________________