DEROSACENTER
Plastic Surgery
BOSTON | PALM BEACH

PT ID#_____ **Patient's Name**_____

Birthdate _____ **Age** _____ **Height** _____ **Weight**_____

Address_____

Phone Number _____ **Email**_____

Reason for Visit:_____

How did you hear about The DeRosa Center? _____

Emergency Contact Name _____ **Relationship**_____

Emergency Contact Phone Number _____

Primary Care Doctor _____

Pharmacy _____

Patient Medical History

□ Healthy/No Past Medical History
□ Acne
□ Abnormal Bleeding/Blood Clots
□ Anesthesia Complications
□ Cancer/ Skin Cancer
□ Diabetes
□ Endocrine
□ Other: _____
□ Heart/ Cardiovascular
□ Infectious Diseases
□ IVF Treatment (Current)
□ Keloids/Hypertrophic Scarring
□ Lungs/ Pulmonary
□ Melanoma
□ Myasthenia Gravis
□ Pacemaker / AICD
□ Pregnant/Breastfeeding
□ Shingles History
□ Cold Sore History

Previous Surgeries with Dates (Include any Anesthesia Issues) - _____

_____

Allergies to Medication(s): _____

Latex Allergy? Yes No **Environmental Allergies**? Yes No

Medications: _____

_____

DEROSA FACIAL PLASTIC SURGERY, PC
91 NEWBURY ST., SUITE 300, BOSTON MA 02116
INFO@DRJAIMIEDEROSA.COM P 617 262 8000
WWW.DRJAIMIEDEROSA.COM F 617 262 8002

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Are you currently on Accutane? Yes No

If previously on Accutane, when did you stop treatment? _____

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Occupation/ Hobbies: _____

Do you smoke? (Cigarettes, Marijuana or Vape) ? Yes No
If yes, how many times a day? _____ When did you start/stop? _____

Patient Family History:

□ No Contributing Family History
□ Abnormal Bleeding/ Clotting
□ Adopted
□ Anesthesia Problems
□ Malignant Hyperthermia
□ Nasal Breathing Difficulty
□ Skin Cancer
□ Other

Review of Systems- Please Review the list and check the box if you have an issue/concern

□ All Normal
□ Allergic/ Immunologic
□ Cardiovascular
□ Constitutional
□ Ear, Nose, Mouth, Throat
□ Eyes
□ Endocrine
□ Gastrointestinal
□ Genitourinary
□ Hematologic/ Lymphatic
□ Musculoskeletal
□ Neurological
□ Psychiatric

How would you describe your skin: _____
History of Melasma/Hyperpigmentation? Yes No **History of Psoriasis or Eczema?** Yes No

Have you ever seen an aesthetician or skin specialist for your skin? Yes No
If yes, when was your last treatment? _____

Are you using any of the following topical skin treatments? (please circle)
Accutane Adapalene Atralin Duac Differin Doxycycline Epiduo Glycolic or AHAs
Retin-A Retinol Salicylic Acid Tretinoin Ziana **NONE** Other: _____

If yes, when was the last use? _____

The above information is accurate and complete to the best of my knowledge. I will inform the staff at the DeRosa Center if anything changes.

Patient's Signature_____**Date** _____

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Patients Name: _____ Date: _____

PLEASE READ AND SIGN

I authorize DFPS to take photographs and/or motion pictures (videos) of me and the treatments rendered to me by Dr. DeRosa and the staff of the DeRosa Facial Plastic Surgery PC (DBA DeRosa Center).
I understand that I will need to provide additional permission to authorize the use of such materials in marketing publications, including the DeRosa Center website. Under NO circumstance will any such publication, film, photograph, videotape, or material exhibited contain my name except within the medical record.

I acknowledge that I may have a copy of the DeRosa Facial Plastic Surgery P.C. Notice of Privacy Practices, the DeRosa Center Patient Bill of Rights Form and the Patient Responsibilities Form. I acknowledge that I have the right to decline to receive a copy of these forms.

I acknowledge that email and text may not be secure and that I give permission to this mode of communication.

I understand this office does not accept insurance of any kind and will not submit claims following office visits. In proceeding with the DeRosa Center, I am electing to pursue any appointments or procedures self-pay and understand that I will not have any portion covered by an insurance company. Irrespective of whether my office visit, procedure, and/or surgery is covered by an insurance plan, I will be responsible for the costs of any services I receive in this office or any surgeries performed. The fees charged do not include any potential future costs for additional procedures that I elect to have or require to revise, optimize, or complete my outcome. Additional costs may occur should complications develop from treatment or surgery.
I acknowledge and accept responsibility for financial costs, regardless if they may be covered by insurance.

I understand that the DeRosa Center does not offer refunds on services rendered, retail items, packages, or memberships.

I understand that if I am purchasing a treatment package, I understand the following: The package cannot be transferred to another service or another patient, The purchased package is non-refundable once a treatment in the package has occurred.

I acknowledge that the possibility of an adverse reaction to any treatment and/or use of products can occur and that this is the case regardless of precautions taken. I understand that no refunds are given for services rendered. I accept sole responsibility for the treatments I receive and for any medical care that may become necessary. I will immediately contact the DeRosa Center if any adverse reactions or concerns. If I cannot reach the office, I will immediately seek medical care. I understand that there is a 14-day return policy for any purchased skin care products found to cause adverse reactions and/or are defective and must be approved for return by a DeRosa Center Provider.

I understand that some people experience peeling of their skin but some may not after a chemical peel. The lack of peeling is not an indication that the treatment was not successful.

I hereby release the DeRosa Center, its agents, owners, employees, successors and assigns, and suppliers from any damage or injury that may result from the treatment I receive. I represent that all the information provided by me has been true and correct. I will let the Providers know if anything changes in subsequent visits. I understand there are no refunds for services rendered.

I understand that a skin evaluation by Provider at the DeRosa Center is not a substitute for routine Dermatological skin evaluations for skin cancer or other skin diseases.

I agree with the $100 No-Show or Late-Cancel (within 48 hours) Fee for all missed appointments and authorize the DeRosa Center to charge my card on file. I understand If I need to change or cancel my appointment, I will do so at least 48 hours before my scheduled appointment time.

Patient's Signature:_____**Date** _____

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