Michael B. Stevens •MD•PhD•FACS
Board Certified Plastic Surgeon

Name:____
(First) (Last) (Middle)

Date of Birth:________/______/______ Age:_______

Occupation:____

Address:____
(Number) (Street) (City) (State) (Zip)

May we contact you by email? ☐ Yes ☐ No
Email Address:____

Primary Contact Number: ____________________Secondary Number:__________________

Emergency Contact:____
(First & Last Name) (Phone) (Relation)

Have you been a patient of Dr. Michael B. Stevens? If yes, what year? ☐ No ☐ Yes___________

Have you been seen by Kendel, with Dr. Stevens' office for Skin Health? ☐ No ☐ Yes

Would you be willing to give CreekSide/ Topograph permission to use your name, biographical information, personal story and photographic likeness in all forms of media? ☐ No ☐ Yes
*Additional Consent Required Before Use

How did you hear about us?____

Reason for the visit____
____
____
____

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Which procedures have you had in the past?
(Please check all that apply)

________ Botox
________ Tattoo Removal
________ Injectable Fillers (i.e. Juvederm, Radiesse, Voluma)
________ Laser Hair Removal
________ Facials
________ Permanent Makeup or Microblading
________ Microdermabrasions
________ Laser Resurfacing (i.e. Fraxel, Halo, CO_2)
________ Chemical Peels
________ Photofacial/IPL/BBL
________ Microneedling with or without PRP
________ Waxing
________ Lash/ Brow Tinting
________ Electrolysis
________ Facial Cosmetic Surgery:____________________
____
________ None of the above

Which procedures are you interested in?
(Please check all that apply)

________ Botox
________ Tattoo Removal
________ Injectable Fillers (i.e. Juvederm, Radiesse, Voluma)
________ Laser Hair Removal
________ Facials
________ Microdermabrasions
________ Laser Resurfacing (i.e. Fraxel, Halo, CO_2)
________ Chemical Peels
________ Photofacial/IPL/BBL
________ Microneedling
________ Waxing
________ Lash/ Brow Tinting
________ Electrolysis
________ Facial Cosmetic Surgery:____________________
____
________ None of the above

Authorization for Treatment and Financial Disclosures
I authorize treatment for the person named on this form and agree to pay all charges for such treatments. I agree to pay all charges for me and members of my family at time of service. I authorize the release of any information regarding my treatment needed to resolve any billing dispute.

If unable to keep an appointment, CreekSide requires a **48 hour notice for any single treatment, and 72 hour notice for any two or more treatments.** If CreekSide is not notified prior to your appointment, there will be a $50.00 service charge per treatment. As a friendly reminder we have a no children and no cell phone policy.

(NO EXCEPTIONS) Thank you for your understanding and consideration.

Signature: ______________________________________ Date: ____________________

Confidential Medical Information

Michael B.Stevens •MD•PhD•FACS
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Name: ____ Date:__________________________

Do you now have, or have you ever had, any of the following? Please check all that apply:

- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Blood Pressure H/L
- ☐ Broken/ Fracture Bones
- ☐ Cancer/Chemo
- ☐ Chronic Pain
- ☐ Depression/ Anxiety
- ☐ Diabetes
- ☐ Digestive Disturbances
- ☐ Dizziness
- ☐ Easy Bruising
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fatigue/ Sleep Disorder
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ Herpes/Shingles
- ☐ Implanted Medical Devices
- ☐ Jaw Pain/TMJ
- ☐ Lymphedema
- ☐ Nail/Skin Fungus
- ☐ Numbness/Tingling
- ☐ Open Sores/Ulcers
- ☐ Pacemaker
- ☐ Permanent Makeup
- ☐ Currently Pregnant (____Weeks)
- ☐ Currently Breastfeeding
- ☐ Rashes
- ☐ Sinus Problems
- ☐ Spasms/Cramps
- ☐ Sprains/Strains
- ☐ Spinal/Bone Problems
- ☐ Stroke
- ☐ Swelling
- ☐ Tattoos
- ☐ Varicose Veins
- ☐ Warts
- ☐ Wear Contact

Other:____

Do you have a history of Keloids or Hypertrophic Scars: ☐ Yes ☐ No

Do you Tan: ☐ Yes ☐ No How: ☐ Direct Sun ☐ Tanning Bed ☐ Spray Tan

Are you under the care of a physician: ☐ Yes ☐ No Last Visit:_________ Dr.___________________

Are you allergic to:☐ Milk ☐ Apples ☐ Grapes ☐Aloe Vera ☐ Aspirin ☐Hydroquinone ☐ Kojic Acid ☐ Pineapple

Other (Please list): ____

Allergic to any medications and/or chemicals?:____

Do you use/take: ☐ Accutane ☐ Aspirin ☐ Blood thinners ☐ Retin-A ☐ Other Rx skin topical products

Other Rx medications (Please list):____

Have you been on any antibiotics in the last 10 days? If yes, when was your last dose?_______________

Have you recently had a: ☐ Chemical Peel ☐ Laser Resurfacing ☐ Botox/Fillers If yes, when?____________

What products are you currently using on your skin?:______________________________________

____

Treatment Consent Form

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- Prior to receiving treatment, I have been candid in revealing any conditions that may have bearing on this procedure, such as: pregnancy (if so, do not do treatment), recent facial surgery,allergies, tendency to cold sores/fever blisters, use of Retin-A, Accutane, antibiotics, steroids, or hormones.
- I understand there may be some degree of discomfort; i.e. stinging, pin pricking sensation, hotness, tightness or possible pigmentation.
- I understand there are no guarantees as to the result of this treatment, due to many variables such as: age, conditions of skin, sun damage, smoking, climate, etc.
- I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.
- I understand that to achieve maximum results, I may need several treatments.
- I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the clinician who performed the treatment.
- I agree to refrain from tanning and tanning booths while I am undergoing treatment and 14 days following treatment.
- I understand that direct sun exposure is prohibited while I am undergoing a chemical peel or laser treatment and that the use of sunblock protection with the minimum of SPF 35 is mandatory.
- I have not had any other peel treatments of any kind within 14 days of this treatment, with the exception of glycolic acid peels which can be performed once or twice a week. I understand I cannot have another treatment within 14 days of this treatment, whether the treatment is performed at this location or any other location.
- I consent to the administration of medication, and local topical anesthetics to be applied by or under the direction of Michael B. Stevens, MD, PhD,FACS.
- I understand that the practice of medicine is not an exact science and that the exact outcome of each treatment cannot be predicted with accuracy.

I hereby agree to all the above and agree to have this treatment performed on me. I further agree to follow all post care instructions as I am directed.

Signature:____ Date:____________________