Michael K Bowman MD PC
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New Patient information Sheet

Date: _____

Name: _____ Age: _____

Birth Date: _____ Height: _____ Weight: _____

How did you find us? _____

Martial Status (circle one): Married - Single - Divorced - Widowed

Sex (circle one): M F Race:_____

Work:_____ Home:_____

Cell:_____

Please circle best contact number above

Address: _____

City:_____ State:_____ Zip Code:_____

E-mail address:_____

May we put you on our email list for specials, promotions, & coupons? YES NO
We will never sell or give out your contact information

Emergency contact:_____ Phone #:_____

Relationship to you:_____

Please list ALLERGIES to medicines, latex or supplements: (List medication & reaction)

_____

Please list all MEDICATIONS & SUPPLEMENTS:

_____

_____

_____

Please list all your MEDICAL PROBLEMS (Treated or untreated):

_____

_____

_____

_____

Please list all surgeries you have had, including cosmetic surgeries (LIST SURGERY AND APPROXIMATE YEAR:)

_____

_____

_____

SOCIAL HISTORY:

Do you use tobacco? ☐ Never ☐ Cigarettes _____ packs/day ☐ Cigars ☐ Pipe ☐ Dip

☐ I quit smoking/use of tobacco as of_____

How many years have/did you use tobacco? _____

Do you normally have more than 2 drinks of alcohol per day? ☐ Yes ☐ No

What is your occupation? _____

YOUR REGULAR/FAMILY PHYSICIAN & DATE OF LAST EXAM:

_____

LIST ANY OTHER PHYSICIANS YOU HAVE SEEN IN THE LAST SIX (6) MONTHS:

_____

Do any medical problems run in your family? _____

Are you frequently sick or ill? ☐ Yes ☐No

Do you drink more than 6 cups of coffee per day? ☐ Yes ☐No

Have you ever been under the care of a psychologist or psychiatrist? ☐ Yes ☐No

Have you been diagnosed with depression or other psychiatric problem? ☐ Yes ☐No

If yes, please explain.

_____

_____

Is there anything else about your health history we should know? If so please list:

_____

_____

_____

Do you understand that medical and surgical treatments cannot promise or guarantee a good outcome?

☐ Yes ☐ No

Do you understand that all risks and complications cannot be prevented when a surgical procedure is performed?

☐ Yes ☐ No

Please list your current skin care regimen:

_____

_____

Have you ever had (check all that apply):

☐ Botox/Dysport/Xeomin ☐ Dermal fillers (Juvederm, Restylane, Voluma, Radiesse)
☐ Sculptra ☐ Eye rejuvenation

****** NOTE ******

THIS IS A CONFIDENTIAL REPORT OF YOUR MEDICAL HISTORY. INFORMATION CONTAINED HEREIN WILL NOT BE RELEASED TO ANY PERSONS EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO.

REGARDLESS OF INSURANCE COVERAGE, I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF ALL CHARGES INCURRED FOR SERVICES RENDERED TO ME OR THE PATIENT NAMED ABOVE.

Signature: _____ Date: _____

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MEDICAL PHOTOGRAPHY & VIDEO CONSENT FORM

In connection with the medical services, which I am receiving from Dr. Bowman or Cawthon, I consent that photographs & or video may be taken of me or parts of my body under the following conditions:

A. The photographs/videos may be taken only with the consent of my physician and under such conditions and at such time as may approved by him or her.

B. The photographs/videos shall be taken by my physician or by a photographer approved by my physician.

C. The photographs/videos shall be used for medical records and media purposes, and, if in the judgment of my physician, medical research, education, or science will benefit from their use, such photographs and information related to my case may be published and republished, either separately or in connection with each other, in professional journals, books, pamphlets, or the internet, or used for any other purpose that he/she may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.

Patient's Name (PRINT): _____

Patient's signature _____

Witness_____

Date _____/_____/_____ Phone (_____) _____ - _____

If patient is a minor or patient is unable to affix signature:

Proxy/Guardian's Name (PRINT):
_____

Proxy/Guardian's Signature (Relationship):

_____

River Region Facial Plastics

Beautiful. Natural. Results.

Please review and sign our appointment and scheduling policies:

- Payment is due at the time of service for all procedures except surgery.
- Surgeries must be paid in full 2 weeks prior to surgery time.
- A $500 deposit is required to schedule a surgical procedure. This deposit is applied to your surgical fees.
- If you choose to cancel surgery more than 48 hours prior to your scheduled time, your payments will be refunded minus the $500 deposit. This $500 deposit may be applied towards any other purchases, products or procedures.
- If you choose to cancel surgery <48 hours prior to your scheduled time, NO REFUND WILL BE GIVEN. Any refunds will be at the discretion of your physician.
- The surgical fees may be applied towards any other purchases, products or procedures.
- Physician No Show appointments will require a $50 consultation fee to rebook, $25 for spa services. All fees can be applied to services.
- Cancellations on the day of appointment 2 or more times will require a non refundable $50 consult fee that can be applied toward a service.
- All price quotes are valid for 90 days.

I have read and understand the above appointment and scheduling policies:

Name: _____ Date:_____

Witness _____ Date:_____

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NICOTINE POLICY ACKNOWLEDGEMENT

Cigarettes, cigars, and tobacco contain harmful ingredients, which include nicotine and carbon monoxide. Nicotine causes vasospasm of the vessels. Vasospasm in simple terms is a contraction of the vessel, which causes narrowing and restriction of blood flow. Carbon monoxide binds oxygen and does not allow the oxygen that we breathe to be released into the areas that need it so desperately, such as the skin. That is why smoker's skin is much more wrinkled and weathered than non-smokers, and their skin ages much faster because they simply deprive their skin of oxygen through the vasospastic effect of nicotine and the binding effect of carbon monoxide described above. This weathered skin looks more aged than the patient's chronological age. Therefore, after successful cosmetic surgery, which can be highly beneficial in eliminating the gravitational and the natural aging process, the weathered skin would detract from an otherwise optimal cosmetic outcome, due to the fact that the skin is in such poor shape.

If this is not enough, there is even a more dangerous effect of smoking or using nicotine products with surgery. In any type of surgery the skin is incised and elevated, and its blood supply is decreased temporarily. In almost every instance, with healthy skin this temporary decrease in blood supply during healing is well tolerated. The effects of nicotine and carbon monoxide described above can take an otherwise healthy skin flap and cause such a decrease in blood supply that the skin will actually die. Despite precautions, additional risks such as infection, scarring, hematoma, and tissue loss in patients with a smoking/nicotine history can occur. This is certainly not the desired end point in cosmetic surgery.

Therefore, due to the dangers of smoking or using nicotine products, patients who have a smoking history and have not yet quit will be required to quit smoking at least 6 weeks prior to surgery, the amount of time necessary for nicotine and other harmful ingredients to leave the body. A series of three (3) nicotine urine tests will be administered 2 weeks prior to surgery, day of surgery and 1 week after surgery. Cost of this mandatory testing will be the patients responsibility for a total of $60.00 ($20.00 each test). Please note that use of nicotine patches and gum will create a positive nicotine urine test.

Please note that the Physician's and staff enforce the right to cancel any surgical procedure at their discretion for non-compliance and/or a positive nicotine urine test.

I have been informed the Physician and his staff, that the risk of cosmetic surgery is significantly increased in patients who smoke or have been smokers. I have also been informed that I must undergo a series of 3 nicotine urinalysis in which I will be responsible for all costs associated with this testing. If I am deemed as non-compliant or do not pass these tests, I understand that the Physician and his staff reserve the right to cancel my surgical procedure.

- ☐ I am a nonsmoker.
- ☐ I was a previous smoker. It has been _____ months since I've smoked a cigarette.
- ☐ I am a smoker and have read and agree to the above.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date