Cosmetic Interest Questionnaire

Patient Name: | Date :

Skin concerns/treatments that interest you (please check all that apply):

FACE:
- ❑ Botox/Dysport
- ❑ Brown/Red Spots
- ❑ Crepiness
- ❑ Facial Fillers
- ❑ Facial Veins
- ❑ Fat Reduction
- ❑ Double Chin
- ❑ Hair Removal
- ❑ Lines/wrinkles
- ❑ Longer Eyelashes
- ❑ Skin Resurfacing
- ❑ Skin Tightening
- ❑ Thin Lips

BODY:
- ❑ Cellulite
- ❑ Fat Reduction
- ❑ Hair Removal
- ❑ Skin Tightening
- ❑ Stretchmarks
- ❑ Varicose/Spider Veins
- ❑ Tattoo Removal
- ❑ Hair Restoration

FEMININE WELLNESS:
- ❑ Hormone Imbalance
- ❑ Vaginal Tightening
- ❑ Vaginal Dryness
- ❑ Leaky Bladder
- ❑ Decreased Sexual Desire
- ❑ Hair Loss

COSMETIC SURGERY:
- ❑ Blepharoplasty (eyelid)
- ❑ Brazilian Butt Lift
- ❑ Breast Surgery
- ❑ Facelift/Necklift
- ❑ Fat Transfer
- ❑ Laser Lipo/Liposuction
- ❑ Lesion Removal/Mole
- ❑ Rhinoplasty/Nose
- ❑ Tummy Tuck

JUST FOR MEN:
- ❑ PRP male enhancement
- ❑ Eyelid surgery
- ❑ Hair Loss
- ❑ Fat Loss
- ❑ Tattoo Removal
- ❑ Hair Removal
- ❑ BOTOX for sweating
- ❑ Fine Lines/Wrinkles

Please answer by circling the appropriate number:

When looking at my face in the mirror, I believe I look younger than, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

When looking in the mirror, I notice, somewhat notice, or do not notice my lashes getting thinner or shorter or lighter over time.

Not Noticeable		*Somewhat Noticeable*		*Very Noticeable*
1	2	3	4	5

Which of the following best describes your skin type? (Please circle one)

I Always burns, never tans
II Always burns, sometimes tans
III Sometimes burns, always tans
IV Rarely burns, always tans
V Brown, moderately pigmented skin
VI Black skin

Help us get to know you!

1. What hobby would you get into if time and money weren't an issue? _____
2. What is something you like to do the "old fashioned" way? _____
3. How do you unwind/decompress? _____
4. What fad/trend do you hope comes back? _____
5. Name something a ton of people are obsessed with but you just don't see the point _____

Best phone number to reach you:	
Email address:	

Patient Signature: ***Date:***

Ritacca Cosmetic Surgery & Medspa

PLEASE PRINT LEGAL NAME ***Please fill out completely,(no blanks or cross outs)***

DATE:_____ REASON FOR VISIT _____

Mr.__ Mrs.__ Ms__ Miss__ Dr__ SEX: M / F

FIRST NAME:_____ MI:___ LAST NAME:_____ NICK NAME:_____

DATE OF BIRTH:_____/_____/_____ AGE:_____

RACE: _____ ETHNICITY: _____ LANGUAGE PREFERRED: _____

MAILING ADDRESS_____ CITY/STATE/ZIP: _____

HOME PHONE:_____ DAY PHONE:_____ CELL PHONE: _____

EMAIL ADDRESS:_____ (*By entering your email address, you agree to receive emails from Ritacca Cosmetic Surgery & Med Spa and/or trusted third parties containing promotions, appointments or other information as needed)*

OK to receive special offers and discounts via the above email & phone and text?
Yes or No (circle one)

PRIMARY CARE PHYSICIAN'S NAME: _____PHONE NUMBER:_____

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED _____*(circle one)*

SPOUSE'S NAME: _____ SPOUSE'S PHONE: _____

PARENT'S NAME (IF PATIENT IS A MINOR): _____

I authorize the release of my personal medical information to the below persons.
(MUST list an Emergency contact)

	Emergency Only	All Information
Contact 1: (name) _____Phone: _____	_____ Initials	_____ initials
Contact 2: (name)_____Phone: _____	_____ Initials	_____ initials

How did you select our office?

___ Google.com ____ Social Media: Which platform? _____

___ Ritaccalasercenter.com _____Doctor :_____

___ Friend/Family _____ RealSelf.com _____ Yelp.com

BELOW IS FOR INSURANCE PATIENTS ONLY

Most insurance policies pay only a portion of your total charges.
If you have questions about your coverage(s),
please contact your insurance representative.
We do not guarantee the accuracy of benefit information given to us by insurance companies!
I understand that a third party billing company will be used for medical insurance claims and any subsequent patient billing for any coinsurance, deductibles or account balances:
Advanced Healthcare Solutions, Inc. (773) 935-4700
I understand that I am financially responsible for my care
In addition, should the insurance company deem these services medically unnecessary or if there remains a patient balance due, it will be MY financial responsibility IN FULL.
I am also responsible for any collection fees or attorney's fees related to my care and subsequent financial balance due.

Sign:_____ **Date:**_____

Primary Insurance
Insurance Company Name:
ID No:
Group No.:
Primary Member's Name:
Primary Member's Last 4 of SSN:
If Tricare: Need Full Primary Member's SSN:

Secondary Insurance
Insurance Company Name:
Id No:
Group No:
Insurance Member's Name:
Insurance Member's Last 4 of SSN:
If Tricare: Need Full Insurance Member's SSN:

RITACCA COSMETIC SURGERY & MEDSPA

Medical History Questionnaire

Name: _____ Date: _____

Please circle (P) if you, the ***Patient*** or (F) if a ***Family*** **member** has experienced any of the following:

P F AIDS / HIV
P F Anesthesia Allergy
P F Anemia
P F Angina
P F Arthritis
P F Artificial Heart Valves of Joints
P F Asthma / Emphysema
P F Back Problems
P F Bleeding Disorders
P F Cancer
P F Chemical Dependency
P F Chest Pain
P F Chronic Diarrhea
P F Chronic / Frequent Cough
P F Circulatory Problems
P F Dentures / Bridges / Loose Teeth
P F Diabetes
P F Ear / Hearing Problems
P F Easy bruising
P F Epilepsy
P F Eye Problems
P F Fainting
P F Foot Problems
P F Ulcers
P F Foot / Leg Cramps
P F Forgetfulness
P F Gout
P F Prescribed Vit.A (Retin A, Renova)
P F High Blood Pressure
P F Rheumatoid Arthritis
P F Collagen Vascular or Autoimmune
P F Dry Eyes or Blepharitis

P F Kidney Problems
P F Liver Disease
P F Low Blood Pressure
P F Lupus
P F Memory Loss
P F Nervousness
P F Psychiatric Care
P F Radiation Treatment
P F Rashes /Eczema
P F Respiratory Disease
P F Rheumatic Fever
P F Seizure Disorder
P F Shortness of Breath
P F Sinus Problem
P F Skin Cancer
P F Stroke
P F Swelling in Hands or Feet
P F Swollen Glands in Neck
P F Throat Pain
P F Tired Feet
P F Tuberculosis
P F Headaches

P F Heart Disease
P F Varicose Veins
P F Venereal Disease
P F Weight Loss / Gain
P F Rosacea
P F Cold Sores
P F Lupus or Sjorgren's
P F Psychiatric / Antidepressants
P F History of Ocular disease or Surgery

List any medical problems or diseases you are being treated for or have been treated for in the past. None □

_____

_____

Past Surgeries: None □ _____

Past Hospitalizations: None □ _____

Other Doctors Caring For You: None □ _____

Medications You're Taking: None □ _____

Pharmacy Name and Telephone:_____

How often do you exercise? _____

Current Height: _____ Current Weight: _____

Do you smoke? Y / N # of years? _____ # of packs / day _____

Do you drink alcoholic beverages? Y / N Amount consumed / week_____

Are you ***Allergic to*: *Please circle***

Y N Adhesive Tape
Y N Aspirin
Y N Codeine
Y N Latex
Y N Iodine Seafood
Y N Novocaine
Y N Penicillin
Y N Prior Anesthetic Problems
Y N Sulfa Drugs
Y N Demerol

Please list any other allergies below:

- **Do you Take Accutane or Amiodarone ? Y / N are you Pregnant or Nursing? Y / N**

Signature: _____ Date _____