



at TURKLE & ASSOCIATES
PATIENT ASSESSMENT PROFILE

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

DATE OF BIRTH: _____ SEX: _____

HOW WERE YOU REFERRED TO US? _____

(The following information is necessary to evaluate and meet your individual needs for Professional service and home care maintenance. All information is confidential)

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

- | | |
|---------------------------|---------------------------|
| _____ STROKE | _____ CANCER |
| _____ LEUKEMIA | _____ DIABETES |
| _____ HEPATITIS | _____ ASTHMA |
| _____ HEART ATTACK | _____ PACEMAKER |
| _____ BLEEDING TENDANCIES | _____ HIGH BLOOD PRESSURE |
| _____ CONGENITAL HEART | _____ AIDS |

MEDICAL HISTORY (include major surgeries, infertility treatments etc.):

ALLERGIES: _____

TYPES OF MEDICATIONS YOU ARE CURRENTLY TAKING:
(Including hormones, vitamins, birth control, aspirin, etc.)

HAVE YOU BEEN SEEN BY A DERMATOLOGIST/PLASTIC SURGEON?
YES _____ NO _____
IF SO, WHAT REASON? _____

ARE YOU TAKING OR HAVE YOU TAKEN ACCUTANE?
YES _____ NO _____
IF SO, FOR HOW LONG? _____

ARE YOU TAKING AN ORAL ANTIBIOTIC FOR ANY SKIN CONDITION?
(i.e., Tetracycline, Minocycline, Doxycycline, Sulfa...)

IF SO, FOR HOW LONG? _____

HAVE YOU FORMALLY BEEN DIAGNOSED WITH A SKIN CONDITION?
(i.e., eczema, rosacea, psoriasis...)

DO YOU USE A TOPICAL PRESCRIPTION CREAM?

(i.e., Differin, Metrogel, Benzamycin Gel...)

IF SO, FOR HOW LONG? _____

DO YOU USE RETIN-A OR RENOVA? YES _____ NO _____

IF SO FOR HOW LONG? _____

ARE YOU PREGNANT OR LACTATING? YES _____ NO _____

HAVE YOU EVER (OR ARE CURRENTLY) GONE TO TANNING BOOTHS?

YES _____ NO _____

DO YOU HAVE A HISTORY OF FEVER BLISTERS OR COLD SORES?

YES _____ NO _____

IF SO, DO YOU TAKE MEDICATION? WHICH ONE(S)? _____

DO YOU USE A SUNBLOCK DAILY OR ON A YEAR ROUND BASIS?

YES _____ NO _____ IF YES, WHAT STRENGTH? _____

HOW MANY GLASSES OF WATER DO YOU DRINK EVERYDAY? _____

WHEN WAS THE LAST TIME YOU HAD ANY OTHER SERVICE DONE AT ANOTHER FACILITY?

(i.e., peels, microdermabrasion, photo rejuvenation, laser hair removal...)

WHAT IS YOUR HOME SKINCARE ROUTINE? PLEASE INCLUDE BRAND NAMES.

(i.e., Oil of Olay, Clinique, Mary Kay, M. D. Formulations...)

A.M.

P.M.

PLEASE CHECK THE FOLLOING:

NATURAL HAIR COLOR:

- _____ White/Gray
- _____ Blonde
- _____ Strawberry Blonde
- _____ Auburn
- _____ Light Brown
- _____ Brown
- _____ Dark Brown
- _____ Black

EYE COLOR:

- _____ Blue/Green
- _____ Hazel
- _____ Light Brown
- _____ Dark Brown

DOES YOUR SKIN:

- _____ Always Burn/ Never Tan
- _____ Always Burn/ Turn to Tan
- _____ Rarely Burn /Almost Always Tan
- _____ Tan Easily

Financial Responsibility and Photo Release Form
Phases- Turkle & Associates

PHOTOGRAPH RELEASE

I authorize Associated Plastic Surgeons of Indiana, PC, d/b/a Turkle & Associates to use my pre- and post-procedure photographs, in connection with my aesthetic services, for educational and medical purposes. I understand Turkle & Associates will not identify me by name when using my photographs.

Signature (if child, responsible party)

Date

PATIENT FINANCIAL RESPONSIBILITY

Aesthetic Care is an excellent investment in the overall care of an individual, both physically and psychologically, and financial considerations should not be an obstacle in obtaining this important health service. Being sensitive to the fact that different people have different needs in fulfilling their financial obligations, we offer several options in paying for your services. You are able to pay for services via cash, check or credit card. If you are receiving a larger procedure over \$500.00, then you may also arrange for financing through CareCredit or other financing companies which we can refer you to.

These financial options are made for your convenience. Full payment for services is due on the date the service is received. If you are paying for a package, in order to receive the package discounts, you are responsible to pay for the entire package on the date of package purchase. If you will be receiving a procedure that is greater than 1 ½ hour of service, then you will be asked to pre-pay 25% of the total charge for that procedure, when you schedule that service. If you cancel that procedure more than 24 hours in advance of your appointment, the amount will be applied to the date of your service, or refunded to you. If you cancel in less than 24 hours prior to your procedure, you will forfeit your pre-payment fee.

* * * * *

I accept financial responsibility for any products, or services rendered by any member of Associated Plastic Surgeons of Indiana, PC, d/b/a Turkle & Associates.

I understand that there is a 45 day return policy on products. This will allow me to return any products that I am not completely satisfied with, within 45 days of purchase. After 45 days, I understand that there is no refund for returned product.

If it becomes necessary for Turkle & Associates to pursue collection, I agree to be responsible for any costs associated with collection, including but not limited to court costs and reasonable attorney's fees. I understand that there is a cancellation fee for any missed appointment that the office is not given 24 hour notice and I accept responsibility for that fee.

Signature (if a child, responsible party)

Date

TURKLE

associates

Three Penn Mark
11455 North Meridian
Street
Suite 150
Carmel, IN 46032
317-848-0001
877-848-0001

