Patient Intake Packet

The Socialite Hair Co.

Patient Demographics

Field	Patient Information
Full Legal Name	
Date of Birth	
Phone Number	
Email Address	
Physical Address	

Emergency Contact

Field	Contact Information
Contact Name	
Relationship	
Phone Number	

Medical Hair Loss Questionnaire

Why are you seeking cranial prosthetics?

_____
_____

Reason for Hair Loss (Check all that apply):

[ ] Alopecia
[ ] Chemotherapy Treatment
[ ] Medication Related Hair Loss
[ ] Auto-immune Disorder
[ ] Other: _____

When did your hair loss begin?

_____
_____

Describe your hair loss pattern or location of loss:

_____
_____

Has the hair loss been medically diagnosed?

[ ] Yes [ ] No

If yes, please provide the following:

- **Diagnosis:** _____
- **Provider Name:** _____
- **Office/Practice:** _____

Medical History Form

Medical Conditions

Please list any relevant medical conditions:

_____
_____
_____
_____

Current Medications

_____
_____

Allergies

_____
_____

Previous Hair Loss Treatments

Please list any previous treatments (clinical or aesthetic) you have attempted:

_____
_____

Cranial Prosthesis Consultation Questionnaire

What are your goals for your cranial prosthesis?

_____
_____

Is there a "go-to" style that you often wear?

_____
_____

What is most important to you in a unit? (e.g., Security, Comfort, Realism, Ease of use)

_____
_____

Unit Expectations & Preferences

Feature	Preferred Specification
Preferred Length	_____
Preferred Color	_____
Preferred Texture	_____
Preferred Style	_____

What questions or concerns do you have regarding your prosthesis?

_____
_____

Insurance and Payment Information

Payment Method Selection

Please select your intended payment method:

[ ] Self Pay
[ ] HSA / FSA
[ ] Insurance Reimbursement Assistance

Insurance Details

If using Insurance Reimbursement Assistance, please complete the following:

- **Insurance Company Name:**
  _____
- **Member ID:** _____
- **Group Number:** _____

Patient Consent and Acknowledgement

Please initial next to each item to indicate your understanding and consent:

1. **Consent to Consultation:** I hereby consent to participate in a consultation with The Socialite Hair Co. regarding my hair loss and prosthesis needs. _____ (Initials)
2. **Consent to Contact:** I authorize The Socialite Hair Co. to contact me via email or phone regarding my care, appointments, and documentation. _____ (Initials)
3. **Pricing and Policies:** I acknowledge that I have received or been informed of the pricing structures and salon/clinic policies. _____ (Initials)
4. **Timelines:** I understand that custom cranial prostheses have specific manufacturing and delivery timelines which will be discussed during my consultation. _____ (Initials)
5. **Authorization to Discuss Care:** I authorize The Socialite Hair Co. to discuss my medical hair loss needs and documentation requirements with my referring healthcare provider. _____ (Initials)

Signature: _____

Date: