Beginnings
Aesthetic & Wellness

Thomas Theocharides, MD

Thomas Theocharides, MD, FACOG, FRCS(C), FSOGC

Dr. Theocharides received his undergraduate training at the prestigious McGill University in Montreal, Quebec and acquired his medical degree at the University of Sherbrooke in 1980 where he became fluent in French. Dr. Theocharides is internationally trained, with his expertise spanning both coasts of Canada where he was appointed a Fellow of the Royal College of Surgeons of Canada.

Dr. Theocharides (pronounced Thee o ka' ri dis, but better known simply as Dr. T) is at the cutting edge of some of the latest research being one of a handful of doctors investigating non-invasive skin tightening for many body areas, including vaginal. He was the first to introduce SmartLipo™ to Monmouth County and has trained other doctors in advanced techniques for both BOTOX® Cosmetic and fillers. He was instrumental in setting up an entire facility to perform laser liposuction under local anesthesia in another state.

His great interest and passion for aesthetics stems from his unsurpassed dexterity in cosmetic procedures as well as his meticulous nature and artistic eye for beauty and symmetry. He received his aesthetic training from several of the most renowned plastic surgeons and dermatologists including the inventor of the FotoFacial™ procedure. His precise techniques result in beautiful aesthetic enhancements that meet each of his patients' individual needs. Dr. T. realizes that inward and outward beauty are connected. He always has an encouraging word for his patients and while he is open to pray with those that ask, it is never imposed.

BIOGRAPHY

POST DOCTORAL TRAINING

Specialized training in aesthetics with 15 years of experience including **BOTOX®**, **XEOMIN®**, the **Liquid Facelift** (also known as **Facial Volume Restoration**), **Fillers** including VOLUMA®, Bellafill® and Fat Transfer, treatment of **wrinkles & sun damage** with fractional CO2 resurfacing, **acne scars** with **Dermapen® Micro-needling**, the one hour **Silhouette Lift® facelift**, FotoFacial™ (IPL/BBL), **skin tightening** with **ThermiRF®**, **ThermiRase® brow lift**, blepharoplasty, **jowl and neck lift** without surgery, excessive sweating (**hyperhidrosis**), laser hair removal, **sclerotherapy**, **laser liposuction**, **vaginal rejuvenation** including hymenoplasty, labiaplasty, and vaginal tightening.

In addition, **anti-aging treatments with bio-identical hormones** can help restore your hormone balance for a younger you.

EDUCATION

- Faculty of Engineering, McGill University, Montreal, Quebec, Canada with scholarship. Received Diploma of Collegial Studies in 1974.
- Faculty of Science, McGill University, Montreal, Quebec, Canada.
- Faculty of Medicine, University of Sherbrooke, Sherbrooke, QC, Canada. Received M.D. degree in 1980.
- Internship at Rush Presbyterian St-Luke's Medical Center, Chicago, IL.
- Specialty training in Ob/Gyn at the University of British Columbia, BC, Canada where he received his Board Certification.

LICENSURE AND BOARD CERTIFICATION

Licensed in the state of New Jersey since 1996, previously Utah and Indiana
Board Certification in Obstetrics and Gynecology since 1985

HOSPITAL AFFILIATIONS

Monmouth Medical Center, Long Branch, NJ Robert
Wood Johnson University Hospital, Hamilton, NJ
Raritan Bay Medical Center both Old Bridge and Perth Amboy Divisions

MEMBERSHIPS AND FELLOWSHIPS Member

Society of Cosmetogynecologists (ISCGYN) Member
American Academy of Cosmetic Surgeons (AACS)
Member American Academy of Anti-Aging Medicine (A4M)
Fellow of the Royal College of Surgeons of Canada (FRCS(C))
Fellow of the Society of Obstetricians and Gynecologists of Canada (FSOGC)
Fellow of the American Congress of Obstetricians and Gynecologists (FACOG)
Member American Society for Laser Medicine and Surgery, Inc (ASLMS) and Lipo-Suction Surgery

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DEMOGRAPHICS

Thomas Theocharides, MD
804 W. Park Ave, Ocean, NJ 07712
877.9EZ.BEAUTY
www.beginningsaal.com

Personal Information

How do you prefer to be addressed: ________________________________

Name: ____ Birth date: _____-_____-_____ Age:______
LAST FIRST MI MAIDEN/PREVIOUS

Current Status: M / S / D / W / ____

Address: ____ City/State: ________________ Zip: ____________

Home: (________) ________- ___________ Mobile: (________) ________- ___________

E mail: ______________________________________ Alt email: ____________________________________

Employer: ____ Phone: (________) ________- ___________

Contact in case of Emergency: ______________________________ Phone: (________) ________- ___________

SSN: _______ - _______ - __________ Driver's Lic#: ____

Contact Information

Best way to be reached: Mobile Home Work E Mail Letter ________________________________
CIRCLE ALL THAT APPLY

If you are not in, with whom may we leave a message? No one / ________________________________

How may we confirm appointments / follow-up? (circle all that apply / cross out what must not be used)

Call: Mobile / Home / Work Voice mail Text Message Email Letter Postcard __________________

How do you want to learn about specials, Open Houses, promotions, or the latest in aesthetics/wellness?

No thank you / Text Message / Email / Postcard Call: Mobile / Home / Work

How did you find out about us? Internet (please specify which search words used)..................................

Magazine / News Paper / Email / Friend/Family

If referred, Who referred you today? (so they can receive $50 Gift Certificate)...................................

Does your significant other know you're here today? YES / NO

Client Signature: ____ Date: ______________________

Let Beginnings Bring Out The Best In You!

Ministering the Love of God...Through Beauty

♥ 2006-14 Thomas Theocharides, MD / rev: 14.09.24

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wwwbeginningsaal.com

INTERESTS

NAME: ______________________ **DOB**: ____________ **DATE**: ____________

Circle your areas of interest, services you desire, or simply detail your interests below:

Silhouette Lift® Bellafill® BELOTERO® Juvederm™ Radiesse® Restylane® Sculptra® VOLUMA™

Liquid Facelift ThermiTight™ ThermiSmooth™ ThermiRase™ ThermiDry™ ThermiVa™ Thermi250™

Kybella® Turkey Neck BOTOX® XEOMIN® Wrinkles around the Mouth / Eyes Sagging Brow / Chin / Neck

Sun Damage Rosacea Broken Capillaries Acne Scars Enlarged Pores Brown Spots Red Spots

Fine lines & Wrinkles Uneven Texture Fractional Laser Resurfacing (Fraxel®/Thermage®) Skin Tightening

PhotoRejuvenation (IPL) DCL Medical Skin Care Dark Circles Spider Veins Facial Veins Sclerotherapy

Dermapen® Micro-needling Hyperhidrosis (excessive sweating) Laser Hair Removal Permanent Cosmetics

Cellulite Body Sculpting Stubborn Fat Laser Lipo Fat Transfer Urinary leakage Vaginal Dryness

Vaginal Rejuvenation Labiaplasty Hymen Restoration G/O-Spot Enhancement Excessive or Uneven Labia

My specific concerns: ____

Health History (Please circle or complete)

#	Question		
1.	Have you ever had a laser procedure?	No	Yes
2.	Ever had skin resurfacing/chemical peels?	No	Yes
3.	History of cold sore/herpes/recurrent skin infection?	No	Yes
4.	History of neurologic disease or muscle weakness?	No	Yes
5.	History of poor or slow healing/keloid scars?	No	Yes
6.	History of bruising or bleeding disorder?	No	Yes
7.	History of skin cancer or suspicious moles?	No	Yes
8.	Taking gingko, vitamins or any other supplements?	No	Yes
9.	Taking prescription medications/alcohol regularly?	No	Yes
10.	Any allergies to medications/latex/sulfites?	No	Yes
11.	Taken Accutane (isotretinoin)?	No	Yes
12.	Using Retin-A or alpha/beta hydroxyl acids?	No	Yes

FOR WOMEN ONLY (N/A = not applicable):

#	Question			
13.	When was your last period	____________		
14.	Was it normal?	N/A	No	Yes
15.	Are you pregnant/trying to get pregnant?	N/A	No	Yes
16.	Using anything to prevent pregnancy?	N/A	No	Yes
17.	Melasma (mask of pregnancy)?	N/A	No	Yes
18.	Change in skin color with pregnancy?	N/A	No	Yes
19.	Urinary leakage / bladder control?		No	Yes
20.	Concerned about vaginal dryness?		No	Yes
21.	Vaginal looseness / vaginal rejuvenation?		No	Yes
22.	Difficulty reaching orgasms?		No	Yes

I have answered all questions truthfully to the best of my ability. I have had the opportunity to ask about any question that was unclear and have this explained to me to my satisfaction. I will not hold anyone responsible for any adverse reaction that I may have as a result of any false information or information I have not disclosed.

Client Signature: ______________________________ Date: ____________

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♥ 2006-15 Thomas Theocharides, MD / rev: 15.09.23

Beginnings Aesthetic & Laser

HEALTH QUESTIONS

Thomas Theocharides, MD
804 West Park Ave, Ocean, NJ 07712
877.9EZ.BEAUTY
www.beginningsaal.com

NAME:	DOB:	AGE:

PERSONAL PAST HISTORY (circle one for each number: N = no, Y = yes, ? = not sure)

1.	Asthma	N	Y	?	7.	Diabetes	N	Y	?	13.	Reflux/hiatal hernia/ulcers	N	Y	?
2.	Angina	N	Y	?	8.	Lupus/Collagen Vascular dis	N	Y	?	14.	Hepatitis/Jaundice	N	Y	?
3.	Heart attack/murmur	N	Y	?	9.	Cancer	N	Y	?	15.	Alcoholism	N	Y	?
4.	Mitral valve prolapse	N	Y	?	10.	Thyroid disease/goiter	N	Y	?	16.	Drug dependency/abuse	N	Y	?
5.	High blood pressure/stroke	N	Y	?	11.	Anemia	N	Y	?	17.	Nervous breakdown	N	Y	?
6.	Blood clots (legs or lungs)	N	Y	?	12.	Blood transfusion	N	Y	?	18.	Other past problem not listed	N	Y	?

CURRENT MEDICATIONS, VITAMINS, & SUPPLEMENTS – if none check here: ☐

(include ALL vitamins, herbs, hormones and nonprescription medications taken regularly)

Drug Name	Dosage	How long	Doctor	Drug Name	Dosage	How long	Doctor
(1)				(5)			
(2)				(6)			
(3)				(7)			
(4)				(8)			

SURGERIES/HOSPITALIZATIONS/INJURIES/ILLNESSES – if none check here: ☐

REASON/TYPE OF INJURY/HOSPITAL	DATE	REASON/TYPE OF INJURY/HOSPITAL	DATE

SOCIAL HISTORY – HEALTH HABITS

1. Do you smoke? no yes	2. Drink any alcohol daily? no yes	3. Recreational drug use? no yes

SYSTEM REVIEW: N = never had, P = previous problem, C = current problem

1. CONSTITUTIONAL
- a. Weakness or fatigue N P C
- b. Lightheadedness N P C
- c. Frequent bruising N P C

2. CARDIOVASCULAR
- a. Chest pain/Pressure N P C
- b. Shortness of breath N P C
- c. Palpitations N P C
- d. Swelling of legs N P C

3. RESPIRATORY
- a. Chronic cough N P C
- b. Bloody phlegm N P C
- c. Wheezing/Congestion N P C

4. NEUROLOGIC
- a. Tremors or Seizures N P C
- b. Numbness N P C
- c. Difficulty walking N P C
- d. MS / ALS / weakness N P C

5. MENTAL/EMOTIONAL
- a. Depression N P C
- b. Frequent crying spells N P C
- c. Problematic anxiety N P C

6. ALLERGIES:
- Drug N P C
- Latex N P C
- Environmental N P C
- Other ____________________

I have answered all questions truthfully to the best of my ability realizing that failure to disclose health information may increase my risks and/or result in complications. I will not hold anyone responsible for any adverse reaction resulting from any information I have not disclosed.

DATE TODAY	SIGNATURE:

♥ 2006-14 Thomas Theocharides, MD / rev: 14.10.28

BEGINNINGS AESTHETIC & WELLNESS LLC

804 WEST PARK AVE, OCEAN, NJ 07712
3467-3469 RT 9 NORTH, HOWELL, NJ 07731
PHONE: 732-695-2040 FAX: 732-493-1640

THOMAS THEOCHARIDES M.D., F.A.C.O.G.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Beginnings Aesthetic & Wellness LLC may use and disclose protected health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Beginnings Aesthetic & Wellness LLC Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Beginnings Aesthetic & Wellness LLC reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, Beginnings Aesthetic & Wellness LLC, at 804 West Park Avenue, Ocean, NJ 07712.

With my consent, Beginnings Aesthetic & Wellness LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Beginnings Aesthetic & Wellness LLC may send an email or mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Beginnings Aesthetic & Wellness LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Beginnings Aesthetic & Wellness LLC use and disclosure of my PHI to carry out
TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Beginnings Aesthetic & Wellness LLC may decline to provide treatment to me.

______________________________	______________________________
Print Name of Patient or Legal Guardian	Signature of Patient or Legal Guardian
______________________________	______________________________
Patient's Name	Date

I ACKNOWLEDGE THAT I HAVE RECEIVED BEGINNINGS AESTHETIC & WELLNESS LLC NOTICE OF PRIVACY PRACTICES POLICY (OR IT HAS BEEN MADE AVAILABLE TO ME)

______________________________	______________________________
Patient's Name	Date

Beginnings Aesthetic & Wellness LLC

Thank you for choosing Beginnings Aesthetic & Wellness as your aesthetic care specialist. We consider it a privilege that you have chosen us for your aesthetic rejuvenation goals. Please read the below policies carefully.

Cancellation Policy

We value your time…and trust you value ours. To minimize no show appointments and to utilize cancelled appointments for other patients, we ask that you please provide the office 24-hour advance notice if you are unable to keep your appointment. Even if it is after hours, call 877.9EZ.BEAUTY. If no reply call the answering service at 877.844.4557. **There will be a $50.00 charge for missed appointments.** An appointment is considered missed if 24-hour notice is not given or if you are more than 30 minutes late for your appointment.

Financial Policy

We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. We strive to inform you of all the medical aspects of your needs as well as advise you on our payment policies for all cosmetic services. It is important that you understand that all services once rendered are non-refundable. Although many follow-up visits are complementary, additional services most likely will incur additional costs. This may relate to wanting additional BOTOX® or fillers at that visit, for example, or if surgical revisions are necessary. The following is a statement of our Financial Policy. **Please read and sign prior to treatment.**

FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED AND MAY BE REQUESTED JUST PRIOR TO RECEIVING YOUR TREATMENT. THIS WILL ALLOW YOU AND THE DOCTOR TO FOCUS ON YOUR SERVICE AND HAVE THE CONVENIENCE OF LEAVING THE OFFICE WITHOUT WAITING.

TO BETTER SERVE YOU, WE ACCEPT CASH, CHECKS, CARE CREDIT, AND MOST CREDIT CARDS.

WE OFFER INTEREST-FREE PAYMENT PLANS THROUGH CARE CREDIT for qualified applicants. It takes just minutes to prequalify at **www.carecredit.com.** You may choose the 6-month interest free plan for services over $500 and, for services over $1500, either the 6 or 12-month plan. This offer is through Care Credit and may be discontinued at any time.

PLEASE BE SURE TO HAVE ONE OF THESE FORMS OF PAYMENT WITH YOU AT THE TIME OF YOUR OFFICE VISIT. IF YOU DO NOT HAVE A FORM OF PAYMENT ON YOUR PERSON AT YOUR VISIT, WE WOULD BE HAPPY TO RE-SCHEDULE YOUR APPOINTMENT.

I understand that the responsibility for payment of services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered and there will be no refund on services already rendered. In the event of a default, I promise to pay legal interest on the indebtedness, together with such collection cost and reasonable attorney fees as may be required to effect collection of this note.

I have read, understand and agree to the Cancellation and Financial Policies detailed above.

____
PRINT PATIENT NAME

____
PATIENT SIGNATURE

____
DATE

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