



Date _____

Name _____ DOB _____ Age _____

Address _____ City _____ State _____ Zip _____

Best Contact # _____ Email _____

Referred By _____

Emergency Contact _____

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Marital Status _____ Primary Care Physician _____

May we leave messages on your answering machine? ___ Yes ___ No Send you mail? ___ Yes ___ No Email you? ___ Yes ___ No

Allergies:

Please list any food or drug allergies: _____

Lifestyle Information:

- Do you take daily aspirin? ___ Yes ___ No
- Do you smoke? ___ Yes ___ No
- Do you wear daily sunscreen ___ Yes ___ No
- What SPF on face? _____ On body? _____
- Do you use tanning booths? ___ Yes ___ No
- Are you pregnant, lactating, or planning to get pregnant? ___ Yes ___ No

Skin Care History:

Please indicate by brand name the products that you use for daily skin care and bring them to your appointment:

What would you like to achieve with you treatment or skin care recommendations? _____

What would you like to discuss with us today? _____

Cosmetic History

- ___ Botox Injections
- ___ Juvederm/Restylane/Collagen injections
- ___ Laser Treatments
- ___ Chemical Peels (date) _____
- ___ TCA or Phenol peel in the last year
- ___ Dermabrasion, Laser resurfacing
- ___ Microdermabrasion
- ___ Waxing/Tweezing/Electrolysis within the last four weeks
- ___ Sun Sensitivity
- ___ Tattoos/Permanent makeup
- ___ Rosacea/Facial redness
- ___ Acne
- ___ Facial surgery/Face lift (date) _____

Are you presently under the physician's care for any conditions? If so, please describe: _____

Please list all medications you are currently taking, including any herbal or over the counter medications:

Have you ever had a reaction to any of the following?

- ___ Cosmetic Medications
- ___ Sunscreens
- ___ Food
- ___ Fragrance



Medical History

Have you ever had any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Amyotrophic lateral sclerosis | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Motor Neuropathy | <input type="checkbox"/> Abnormal Teeth |
| <input type="checkbox"/> Myasthenia Gravis | <input type="checkbox"/> Abnormal Nails |
| <input type="checkbox"/> Lambert-Eaton Syndrome | <input type="checkbox"/> Fever/Chills |
| <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Polycystic Ovarian Disease (PCOD) |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Cystic Acne |
| <input type="checkbox"/> Neuromuscular Disorders | <input type="checkbox"/> Scars that turn white or brown |
| <input type="checkbox"/> Light Sensitive Epilepsy | <input type="checkbox"/> Lupus or other Auto-immune Deficiency |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cochlear Implants |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Lasik Surgery (date)_____ |
| <input type="checkbox"/> Persistent Headache or Dizziness | <input type="checkbox"/> Implants (location)_____ |
| <input type="checkbox"/> VP Shunt | <input type="checkbox"/> Reaction |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes Simplex or Fever Blisters |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Rheumatoid Arthritis "Gold Therapy" |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Bronchitis or Hay Fever | <input type="checkbox"/> Cancer (describe)_____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hirsutism |
| <input type="checkbox"/> Chest Pain/Palpitations/Heart Murmur | <input type="checkbox"/> Transplant Anti-rejection Drugs |
| <input type="checkbox"/> Bleeding Abnormalities | <input type="checkbox"/> Birthmarks |
| <input type="checkbox"/> Pulmonary Embolism/Blood Clot | <input type="checkbox"/> Treatment with Accutane (date)_____ |
| <input type="checkbox"/> Leg Ulcer or Phlebitis | <input type="checkbox"/> Treatment with Tetracycline in last month |
| <input type="checkbox"/> Blood Thinning Medication | <input type="checkbox"/> Keloid or Thick Scarring |
| <input type="checkbox"/> Coumadin or anti-clotting medication | <input type="checkbox"/> Psoriasis or Vitiligo |
| <input type="checkbox"/> Pacemaker/Implanted Defibrillator | <input type="checkbox"/> Family History of Birthmarks |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Family History of Rashes or Skin Disease |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Family History of Asthma |
| <input type="checkbox"/> Nausea/Vomiting/Diarrhea | <input type="checkbox"/> Family History of Hay Fever |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Family History of Cancer |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Family History of Diabetes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Family History of Bleeding Disorders |
| <input type="checkbox"/> Weight Loss or Gain | <input type="checkbox"/> Lactose Intolerance |
| <input type="checkbox"/> Urinary Problems (Frequency or Pain) | <input type="checkbox"/> Blood In Urine or Incontinence |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Muscle Aches |
| <input type="checkbox"/> Broken Bones | |

Explain anything checked above _____

I understand that all procedures and office visits are considered cosmetic regardless of exclusions from my insurance company. I understand and agree to pay in full for all services rendered on the day of these services are performed.

Signature: _____ Date: _____



Skin Typing

Name _____ Date _____

Please answer the following questions by circling the number which best describes you. Your clinician will total the score.

My ethnic origin is closest to:

| | |
|--|-------|
| I. Very fair (Celtic and Scandinavian) | _____ |
| II. Fair skinned Caucasian with light hair and light eyes | _____ |
| III. Pale skinned Caucasian with dark hair and dark eyes | _____ |
| IV. Olive-skinned (Mediterranean, some Asian or Hispanic) | _____ |
| V. Dark-skinned (Middle Eastern, Hispanic, Asians, Africans) | _____ |
| VI. Very dark-skinned (African) | _____ |

My eye color is:

| | |
|-------------------|---|
| Light blue | 0 |
| Blue/green | 1 |
| Green/gray/hazel | 2 |
| Hazel/light brown | 3 |
| Brown | 4 |

My natural hair color at age 18 was:

| | |
|-------------|---|
| Red | 0 |
| Blonde | 1 |
| Light brown | 2 |
| Dark brown | 3 |
| Black | 4 |

The color of my skin that is not usually exposed to the sun:

| | |
|------------------------|---|
| Pink to reddish | 0 |
| Very pale | 1 |
| Pale with a beige tint | 2 |
| Light brown | 3 |
| Medium to dark brown | 4 |
| Dark brown to black | 5 |

If I go into the sun for an hour or so without sunscreen and have not been in the sun for weeks my skin will:

| | |
|--|---|
| Burn, blister and peel | 0 |
| Burn, then little color change after burn resolves | 1 |
| Burn then turns to tan in a few days. | 2 |
| Get pink and turns to tan quickly | 3 |
| Just tan | 4 |
| Just gets darker | 5 |
| My skin is so dark I can't tell | 6 |

When was the last time the area to be treated was exposed to sunlight, tanning booths or artificial tanning cream:

| | |
|-------------------------|---|
| Longer than 1 month | 0 |
| Within the past month | 1 |
| Within the last 2 weeks | 2 |
| Within the last week | 3 |

Total Score: _____

| | |
|----------------|--------------------|
| Your score is: | Your skin type is: |
| 0-3 | I |
| 4-7 | II |
| 8-11 | III |
| 12-15 | IV |
| 16-19 | V |
| 20-24 | VI |

Notes: _____



HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required or required by law. It also describes your rights to access and control your PHI. "PHI" is information about you, including demographic information, that may identify you, that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses & disclosures of protected health information:

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and for treatment purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Payments: Your PHI will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to a medical students that see patients at our office. In addition, we may use a sign-in sheet at the front desk where you will be asked to sign your name and asked to specify your physician. We will also call you by name in the waiting room when your physician is ready to see you. We may also use your PHI as necessary to contact you about your appointments.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Oversight: Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement: Coroners, Funeral Directors and Organ Donation; Research; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures: Under the law, we must make disclosures to you when when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance requirements of section 164.500.

Other permitted and required uses and disclosures will be made ONLY WITH YOUR CONSENT, authorization or opportunity to object, unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.



Your Rights: The following is a statement of your rights with respect to your Protected Health Information(PHI)

You have the right to inspect and copy your PHI. Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your PHI. This means you can ask us not to use or disclose any part of your PHI for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to any family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and whom you want the restriction to apply.

Your physician is not required to agree to restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to request and receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change terms of this notice and will inform you by mail of any changes. You then have the right to object or withdrawal as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaints. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/before April 14, 2003.

We are required by law to maintain the privacy and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at (530) 243-6085

Signature below is acknowledgment that you received this Notice of Privacy Practices.

Print Name _____ Signature _____ Date _____