



PATIENT INFORMATION & MEDICAL HISTORY

PERSONAL HISTORY

(Please print)

Today's Date _____

Name _____ Date of Birth _____

Age _____ Email _____

Do you want to be added to our monthly email list for special discounts? _____

Home Address _____ Apt # _____

City _____ State _____ Zip Code _____

Social Security _____ Occupation _____

May we call or leave a message at any of the numbers listed below? Home Work Cell

Home Phone _____ Work Phone _____

Cell Phone _____

Emergency Contact Name and Phone _____

Primary Care Physician _____ Phone _____

How were you referred to us? _____

What is the No. 1 reason for choosing us? _____

MEDICAL HISTORY

Height _____ Weight _____

Are you currently pregnant? ___Yes ___No

Are you comfortable with your current weight? ___Yes ___No

What would be considered an ideal weight for you? _____

Past Medical History:

Have you ever been diagnosed/treated for:

- | | |
|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Peripheral Artery Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Loss/Gain of weight |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Bowel irregularities |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Change of appetite |
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Umbilical Hernias |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ingrunal Hernia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Abdominal Hernia |
| <input type="checkbox"/> STD/HIV | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Alcohol Problem | <input type="checkbox"/> Abnormal Pap smear |
| <input type="checkbox"/> Non-Pharmaceutical Drug Dependence | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Pharmaceutical Drug Dependence | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Libido dysfunction/lack of desire |
| <input type="checkbox"/> Breast masses/lumps/cysts/discharge | <input type="checkbox"/> Orgasmic dysfunction |
| <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Skin problems/rashes |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Skin Hyper/Hypo pigmentation |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Skin dryness |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Eczema/Psoriasis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Warts/Nevi |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Herpes/Cold sores |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Spider veins | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> HRT (Hormone Replacement Therapy) | <input type="checkbox"/> Cardio Vascular Conditions |

Date of Last Menstrual Period _____

List Surgeries / Pertinent Hospitalizations: _____

Pertinent Family History:

Has anyone in your family been diagnosed/treated for:

Diabetes

High Blood Pressure

Stroke

Heart Attack

Osteoporosis

Fibrocystic breast

Cancer

Other family diseases _____

Lifestyle:

How many alcoholic drinks do you consume per week? _____

How much caffeine do you consume per day? _____

How many diet beverages do you consume per day? _____

Do you smoke? No Yes How many per day? _____ If quit, when? _____

Do you feel you eat healthy? No Yes

Do you follow a special diet? No Yes

Do you exercise? No Yes

Marital status: Married Single Divorced Widowed Significant Other

Do you have stress in your life? No Yes

Nutritional/Natural Supplements:

Vitamins: _____

Minerals: _____

Herbs: _____

Enzymes: _____

Protein/Oils: _____

Other: _____

List Hormones Previously taken Date Started Date Stopped Reason

Prescribing Doctor: _____ Phone: _____

List Prescription Medications and Reason:

1	5
2	6
3	7
4	8

List Medication Allergies:

1	2
3	4

Check the degree of severity for any symptoms that apply to you:

	Mild	Moderate	Severe		Mild	Moderate	Severe
Weight gain				Heavy/irregular menses			
Bladder symptoms				Fluid retention			
Hot flashes				Hard to reach climax			
Headaches				Irritability			
Mood swings				Hair loss			
Fatigue				Cramps			
Loss of memory				Body aches/joint pain			
Depression				Breast tenderness			
Night sweats				Fibrocystic breast			
Vaginal dryness				Breakthrough bleeding			
Sleep disturbances				Dry skin/hair loss			
Decreased sex drive				Anxiety			
Insomnia				Diarrhea			
Urinary Track Symptoms				Constipation			
Fuzzy thinking				Heat/cold intolerance			

Any additional comments or concerns: _____

External Self:

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

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Hispanic, Asian, Mediterranean, Middle Eastern
- VI Black Skin

Have you ever used Accutane?

Yes No

If yes, when did you last use it? _____

What topical modifications or creams are you currently using?

Retina A Others

(please list) _____

Have you ever had laser hair removal?

Yes No

Have you ever used any of the following hair removal methods in the past six weeks? shaving waxing electrolysis plucking tweezing stringing depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin?

Yes No

Have you recently used any self-tanning lotions or treatments?

Yes No

Do you form thick or raised scars from cuts or burns?

Yes No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma?

Yes No

If yes please describe _____

Are you generally comfortable with your appearance? No Yes

If No, what are your areas of concern or desired treatments?

- | | | |
|---|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hair removal | <input type="checkbox"/> Laxity Skin |
| <input type="checkbox"/> Acne Scars | <input type="checkbox"/> Lines/wrinkles | <input type="checkbox"/> Texture |
| <input type="checkbox"/> Age Spots | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Spider veins |
| <input type="checkbox"/> Botox | <input type="checkbox"/> Nutrition counseling | <input type="checkbox"/> Sun damage |
| <input type="checkbox"/> Cellulite | | <input type="checkbox"/> Tattoo Removal |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Oily skin | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Clogged Pores | <input type="checkbox"/> Radiesse | |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Restylane | |
| <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Rosacea | |
| <input type="checkbox"/> Other _____ | | |
-
-

Skin Condition:

Please list the specific products you are using in each category:

- Cleanser _____ Toner _____ Moisturizer _____
- Eye Cream _____ Exfoliator _____
- Sunscreen _____ Make-up _____

Previous Skin Treatments:

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> CO2 | <input type="checkbox"/> Erbium/YAG laser | <input type="checkbox"/> Fraxel |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Accutane |
| <input type="checkbox"/> Retin-A/Tazorac | <input type="checkbox"/> Tanning | <input type="checkbox"/> Spa Facials |

Are you interested in receiving more information on:

- Facial Rejuvenation
- Laser Tattoo Removal
- Laser Hair Removal
- Skin Treatments
- HCG Medical Weight Loss
- Vitamin B12 Therapy
- Bio Identical Hormones
- BOTOX/Xeomin
- Dermal Filler
- i-Lipo
- Laser Vein Treatment

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's notice of privacy practices.

Please print name

Signature

Date

_____ For office Use Only _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (specify) _____

Credit Card Charge Authorization & Refund Policy Agreement

We request the courtesy of a 24-hour notice in the event an appointment needs to be cancelled or rescheduled. A \$50 no-show fee for laser, spa treatments and appointments will apply in the event that advanced cancellation or rescheduling notice is not given. Appointments booked same day of service will be assessed a no-show fee should cancellation become necessary. For treatments that are pre-paid (including but not limited to Groupon and Living Social), the pre-paid treatment will be forfeited without a 24-hour notice of cancellation. In addition, there are no refunds for products or services after purchase. Prepaid services have a 6 month expiration date with the exception of laser hair removal treatments being a 12 month expiration date. Thank you for your cooperation.

Signature: _____

Date: _____

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

Uses and Disclosures of Protected Health Information

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

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information 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 protected health information in order to support the business activities of your physician's 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 protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment.

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