Patient Profile

Name:_____ DOB:_____

Age:_____ Sex:_____ How did you hear about us?_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Permission to leave a message?_____ To send Emails?_____ To send text messages? _____

In Case of Emergency:_____ Phone: _____

- What is your hereditary background? (circle all that apply)
  - African American / Asian/English / Irish / Hispanic / Mediterranean / Middle Eastern / Native American / Nordic / Scandinavian / Caucasian / Other_____
- Natural Eye Color:_____ Natural Hair Color:_____
- Do you consider your skin (circle best option): Sensitive / Resilient / Unsure
- What are the changes you would most like to see in your skin?_____
  _____
- When was your last visit to a dermatologist office?_____
- When was your last sun exposure of 30 minutes or more?_____
- On average, how many hours per week do you spend outdoors?_____
- Are you pregnant or lactating? ☐ Yes ☐ No
- Do you wear contact lenses? ☐ Yes ☐ No
- Do you participate in vigorous activity or sports? ☐ Yes ☐ No
- Do you smoke or use tobacco? ☐ Yes ☐ No
- Do you have any open lesions? ☐ Yes ☐ No
- Do you currently have a sunburned/wind-burned/or red face? ☐ Yes ☐ No
- Do you tanning beds, self-tanners, or spray tans? ☐ Yes ☐ No

In consideration of our clients and staff, we wish to inform you that if you arrive 15 minutes past your reserved time, you cannot receive an extension of scheduled service time and could be responsible for the full service fee.

We also ask that if you must cancel or reschedule your appointment, please allow us the courtesy of doing so 24 hours prior to your scheduled treatment. Failure to comply with adequate notification of cancellation or rescheduling will result in having to pay for the requested visit prior to another appointment being booked.

Please note that our medical consultations are complimentary; however, if 24 hours' notice is not given, a $25 charge will be applied. We understand that emergencies arise, and we will work with you. This is simply to ensure your arrival.

Medical History

Name: _____

- Are you currently taking any medications, topical or otherwise? ☐ Yes ☐ No
  (Tretinoin® / Retin A® / Renova® / Differin® / Tazorac® / Avage® / EpiDuo® / Ziana®)
- Do you have an autoimmune disorder? ☐ Yes ☐ No
- Have you undergone Accutane® therapy? (isotretinoin)? ☐ Yes ☐ No
- Do you develop cold sores/fever blisters? ☐ Yes ☐ No
- Have you ever been diagnosed with Hepatitis or HIV ☐ Yes ☐ No
- Are you allergic/sensitive to (circle all that apply) milk / apples / citrus / grapes / aloe vera / aspirin / perfumes / latex / hydroquinone / mushrooms?
  If any other allergies, List? _____
- Have you ever used any other products that caused a bad reaction? ☐ Yes ☐ No
  Describe: _____
- Have you had a chemical peel or any type of procedure with a medical device? ☐ Yes ☐ No
  Within the last 14 days? ☐ Yes ☐ No
  What type? _____
- Do you currently use depilatories or wax? ☐ Yes ☐ No
- Do you have regular collagen, Botox® or other dermal filler injections? ☐ Yes ☐ No
- Have you ever had a seizure? ☐ Yes ☐ No
- Do you have migraine headaches? ☐ Yes ☐ No
  Medications: _____
- Do you have a history of keloids or hypertrophic scars? ☐ Yes ☐ No
- Do you have any medical conditions that make you sun sensitive? ☐ Yes ☐ No
- Do you have any implants or permanent make-up in the area being treated? ☐ Yes ☐ No
- List of topical medication you are using on the area being treated? _____
  _____

_____ _____
Signature Date

_____ _____
Witness Date

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Advanced Skin Care, LLC creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting and arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.
4. It may be necessary to release your protected health information to financial parties, credit card entities, banks and finance companies, when requested to facilitate your payment. Services that are performed that are paid with credit card, debit card or finance company are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Advanced Skin Care to use and disclose my protected health information when requested to process an account or assist with payment.

_____ _____

Patient's Name Printed Date

_____ _____

Patient's Signature (Or Guardian, if a Minor) Witness

Client Questionnaire

We value you as a patient, and being able to service your needs/concerns is of the utmost importance; therefore, we kindly ask you to take a few moments to fill out our questionnaire. Your feedback will help us improve our services and adapt them according to your suggestions and wishes.

Please indicate any service you wish to receive additional information or a consult on, and someone from our staff will be happy to provide information:

_____ Botox®

_____ Restylane®

_____ Intense Pulsed Light

_____ Chemical Peels

_____ Microdermabrasion

_____ Hydra-facial

_____ Permanent Make Up

_____ Derma Needling

_____ Massage Therapy

_____ Gift Certificates

_____ Juvederm XC ®

_____Laser Hair Removal

_____ Facials

_____ Waxing

_____ Exilis ®

_____ Mineral Cosmetics

_____ Eyelash Extensions

_____ EPI – Dermal Leveling

_____ Scar Therapy

_____ Medical Grade Skin Care Products

Name: _____

Phone number: _____

Email: _____

Best time to reach you: _____