Patient Intake Form

Client Information and Medical History

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

Client Name _____ **Today's Date** _____

Date of Birth _____ **Age** _____ **Occupation** _____

Home Address _____ **City** _____ **State** _____

Zip Code _____ **Cell Phone** _____ **Home Phone** _____

E-mail address: _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

Do you regularly sun bathe or use tanning salons? How often? _____

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, for what: _____

Do you have any of the following medical conditions? (Please check all that apply)

☐ Cancer ☐ Diabetes ☐ High blood pressure ☐ Herpes ☐ Arthritis ☐ Frequent cold sores
☐ HIV/AIDS ☐ Keloid scarring ☐ Seizure disorder ☐ Skin disease/Skin lesions ☐ Hepatitis
☐ Hormone imbalance ☐ Thyroid imbalance ☐ Blood clotting abnormalities ☐ Any active infection

Additional health problems or medical conditions? Please list: _____

_____

Have you ever had an allergic reaction? (List all that you have had and describe the reaction you experienced)

_____

What oral or topical medications are you presently taking? (It is required that you list all of them):

_____

Photographic Consent:

I give consent to be photographed for the purpose of medical records ☐ Yes ☐ No
I give consent to be anonymously photographed for marketing and/or publication ☐ Yes ☐ No

For our female clients:

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
Are you breastfeeding? ☐ Yes ☐ No
Are you using contraception? ☐ Yes ☐ No

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Patient Signature _____ Date: _____

Fitzpatrick Skin Type

The most commonly used scheme to classify a person's skin type by their response to sun exposure in terms of the degree of burning and tanning was developed by Thomas B. Fitzpatrick*, MD, PhD. Examples are given below.

* Fitzpatrick, T.B. (1988) The validity and practicality of sun reactive skin types I through VI. Arch Dermatol 124; 869-871.

Eye colour

0. Light colours
1. Blue, gray or green
2. Dark
3. Brown
4. Black

Natural hair colour

0. Sandy red
1. Blond
2. Chestnut or dark blond
3. Brown
4. Black

Your skin colour (unexposed areas)

0. Reddish
1. Pale
2. Beige or olive
3. Brown
4. Dark brown

Freckles (unexposed areas)

0. Many
1. Several
2. Few
3. Rare
4. None

If you stay in the sun too long?

0. Painful blisters, peeling
1. Mild blisters, peeling
2. Burn, mild peeling
3. Rare
4. No burning

Do you turn brown?

0. Never
1. Seldom
2. Sometimes
3. Often
4. Always

How brown do you get?

0. Never
1. Light tan
2. Medium tan
3. Dark tan
4. Deep dark

Is your face sensitive to the sun?

0. Very sensitive
1. Sensitive
2. Sometimes
3. Resistant
4. Never have a problem

How often do you tan?

0. Never
1. Seldom
2. Sometimes
3. Often
4. Always

When was your last tan?

0. +3 months ago
1. 2–3 months ago
2. 1–2 months ago
3. Weeks ago
4. Days

Score		
0–6	Skin Type I	Always burns, never tans (pale white skin) 
7–13	Skin Type II	Always burns easily, tans minimally (white skin) 
14–20	Skin Type III	Burns moderately, tans uniformly (light brown skin) 
21–27	Skin Type IV	Burns minimally, always tans well (moderate brown skin) 
28–34	Skin Type V	Rarely burns, tans profusely (dark brown skin) 
35+	Skin Type VI	Never burns (deeply pigmented dark brown to black skin) 

Disclosure and Consent

Botulinum Toxin Treatments

This consent form is designed to provide the information necessary when considering whether or not to undergo Botulinum Toxin Treatments !or facial wrinkles with Botox.

Injected botulinum toxin causes weakness of muscles that can last approximately three months. Injection of small amounts of Botox relaxes the treated muscles and can reduce facial wrinkles such as frown lines. Botox solution is injected with a small needle into the muscles. Typically, effects are seen in a few days and take 1–2 weeks to fully develop.

The risks, side effects and complications of treatment with Botox include, but are not limited to:

- Pain
- Bruising, which resolves within 1–2 weeks after the injection
- Swelling
- Headache
- Undesired change in eyebrow shape
- Rarely, an adjacent muscle may be weakened which may result in a droopy upper or lower eyelid (1–5%) droopy eyebrow.

Post marketing safety data suggests that botulinum toxin effects may, in some cases, be observed beyond the site of local injection. The symptoms may include generalized muscle weakness, double vision, blurred vision, eyelid droop. difficulty swallowing, difficulty speaking, urinary incontinence, and breathing difficulties. These symptoms have been reported hours to weeks after injection. Swallowing and breathing diHicullies can be life threatening and there have been reports of death related to spread of toxin effects. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults, particularly in those patients who have underlying conditions that would predispose them to these symptoms. No definite serious adverse event reports of distant spread of toxin effect associated with dermatologic use of cosmetic botulinum toxin at the labeled dose of 20 units (for frown lines) or 100 units (for underarm sweating) have been reported.

My signature below certifies that I have fully read this consent form and understand the information provided to me regarding the proposed procedure. I have been adequately informed about the procedure including the potential benefits. limitations, alternative treatments, and I have had all my questions and concerns answered to my satisfaction. I understand that results are not guaranteed and I accept the risks, side effects, and possible complications inherent in undergoing Botox treatments.

Patient Signature: _____

Or other Legally Responsible Person's Signature: _____/

Relationship: _____

Date: _____ **Time:** _____ ◯**AM** ◯**PM**

Witness: _____ **Time:** _____ ◯**AM** ◯**PM**

I have explained to the patient or legal representative the disclosure and consent required for the medical, surgical, and/or diagnostic procedures planned as well as the patient's right to withhold consent.

Physician's Signature: _____ **Date:** _____

Disclosure and Consent

Dermal Fillers Treatment

This consent fonn is designed to provide the necessary information to decide whether to undergo treatment with dermal fillers (“fillersn).

Dermal filler treatments are used for the treatment of facial creases, wrinkles, folds, contour defects, depression scars, facial lipoatrophy (loss of fat), and/or lip enhancement. The treatments involve multiple small injections of the filler into or below the skin to fill wrinkles and restore volume. The effects of injectable fillers are temporary and no guarantees can be made regarding how long correction will last in a specific patient.

Alternatives to temporary fillers include, but are not limited to: permanent dermal fillers, laser resurfacing, surgical facelift, lasers for skin laxity, or no treatment at all.

Possible risks, side effects, and complications with dermal fillers Include, but are not limited to:

- Redness and swelling, bruising, infection
- On rare occasions, red bumps or pustules (acne-like lesions) may form
- Discoloration of the skin such as grayish, bluish, or reddish coloration
- Filler material may be extruded from the skin in rare cases
- Visible raised areas or lumpiness aVaround the treated site
- Rarely granulomas, which are firm nodules, may form
- Allergic reaction with itchiness, redness, and in extremely rare cases generalized allergic response such as whole body swelling, respiratory problems, and shock

A remote and rare risk is that of injecting filler into a blood vessel (blood vessel occlusion) or overfilling the tissue, which can block blood flow to the treated area or to distant areas causing tissue damage and tissue death (necrosis). Blood vessel occlusion can result in blindness if filler is injected in a blood vessel near the eye such as in the tear trough or in the frown area. Blood vessel occlusion can result in necrosis (skin death) of the side of the nose or cheek if filler is injected into a blood vessel near the nose or the fold between the cheek and the nose.

My signature below certifies that I have fully read this consent form and understand the written information provided to me regarding the proposed procedure. I have been adequately informed about the procedure including: the potential benefits, risks, limitations, and alternative treatments and I have had all my questions and concerns answered to my satisfaction.

Patient Signature: _____

Or other Legally Responsible Person’s Signature: _____/

Relationship: _____

Date: _____ Time: _____ ◯AM ◯PM

Witness: _____ Time: _____ ◯AM ◯PM

I have explained to the patient or legal representative the disclosure and consent required for the medical, surgical, and/or diagnostic procedures planned as well as the patient’s right to withhold consent.

Physician’s Signature: _____ Date: _____

Notice of Privacy Practices

This is a summarized version of our Notice of Privacy Practices. The purpose of this form is to inform about how we may use and disclose your medical information. The Health Insurance Portability and Accountability Act (HIPAA) is a federal program requiring that all medical records used or disclosed by our office be kept confidential. We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices.

HIPAA requires us to notify you that we may use your medical records for each of the following purpose:

Treatment
- Providing, coordinating, or managing your health care and related services.

Payment
- Obtaining reimbursement for services, confirming insurance coverage, billing, and collection activities and utilization review.

Health Care Operations
- Including business activities or management of our office.

You have the following rights regarding your medical records:
- You may request restrictions on disclosures of your medical records.
- You may review your medical records.
- You may request a copy of your medical record. There may be a charge for this service.
- You may provide an ammendment to your medical record.
- You may request a list of disclosures made from your medical record.

This summarized notice is effective as of 9/12/2013. We reserve the right to make modifications to our privacy notice. The complete version of our Notice of Privacy Practices is always available upon request. If you feel that your privacy protections have been compromised, you may contact our office manager or the Department of Health and Human Services or the Office of Civil Rights.

Patient Consent Form

HIPAA

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for [Insert practice name] to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).
(The Notice of Privacy Practices provided by Santa Cruz Med Spa describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Santa Cruz Med Spa reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Santa Cruz Med Spa, at 2030 North Pacific Avenue, Unit E, Santa Cruz, CA 95060.

With this consent, Santa Cruz Med Spa may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Santa Cruz Med Spa may mail to my home or other alternative 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.”

With this consent, Santa Cruz Med Spa may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that [Insert name of practice] restrict how it uses or discloses my PHI to carry out TPO. 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 allow Santa Cruz Med Spa to use and disclose 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, or later revoke it, Santa Cruz Med Spa may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____

Print Patient’s Name _____ **Date** _____

Print Name of Patient or Legal Guardian, if applicable _____

Patient Information Handout

Botulinum Toxin Treatments

Prior to treatment

- Avoid aspirin (Excedrin), vitamin E, St. John's wort, and other dietary supplements including ginkgo, evening primrose oil, garlic, feverfew, and ginseng for 2 weeks.
- Avoid ibuprofen (Advil, Motrin) and alcohol for 2 days.
- If possible, come to your appointment with a cleanly washed face.

After treatment

- Do not massage the treated areas on the day of treatment.
- Avoid lying down for 4 hours immediately after treatment.
- Avoid applying heat to the treated area on the day of treatment.
- Avoid activities that cause facial flushing on the day of treatment including consuming alcohol, exercising, tanning.
- Gently apply a cool compress or wrapped ice pack to the treated areas for fifteen minutes every few hours as needed to reduce discomfort, swelling, or bruising up to a few days after treatment. If bruising occurs it typically resolves within 7–10 days.
- After treatment oral SinEcch and/or topical Amica montana may help reduce bruising and swelling.
- Botulinum toxin treatment effects take about 1-2 weeks to fully develop and last approximately $2^1/_2$–4 months.
- If 1–2 weeks after treatment you feel that you require a touch-up please contact the office.

Patient Information Handout

Dermal Filler Treatments

Prior to treatment

- Avoid aspirin (any product containing acetylsalicylic acid), vitamin E, St. John's wort, and other dietary supplements including ginkgo, evening primrose oil, garlic, feverfew, and ginseng for 2 weeks.
- Avoid ibuprofen (Advil, Motrin) and alcohol for 2 days.
- If possible, come to your appointment with a cleanly washed face without make up.

After treatment

- Skin redness and swelling in the treatment area are common. This should resolve within a few days. If it persists longer than 3 days please contact your physician.
- Do not massage the treated areas on the day of treatment.
- Avoid applying heat to the treated area on the day of treatment.
- Avoid activities that cause facial flushing on the day of treatment including consuming alcohol, exercising, tanning.
- Gently apply a cool compress or wrapped ice pack to the treated areas for fifteen minutes every few hours as needed to reduce discomfort, swelling, or bruising up to a few days after treatment. If bruising occurs it typically resolves within 7–10 days.
- After treatment oral and/or topical Amica montana may help reduce bruising and swelling.
- If 2–4 weeks after treatment you feel that you require a touch-up please contact your physician.