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

Score	Skin Type	Description
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)

* The information published here is not intended to take the place of medical advice. Please seek advice from a qualified health care professional.

Disclosure and Consent

Medical and Surgical Procedures

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your informed consent to the procedure.

I (we) voluntarily request Dr. ____
as my physician, and such associates, technical assistants and other health care providers as they may deem necessary to treat my condition which has been explained 10 me as ______________________________________.

I (we) understand that the following surgical, medical and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures:

❑ shave ❑ punch biopsy ❑ excision ❑ cryotherapy ❑ electrosurgery ❑ electrosurgery and curellege ❑ Micro Needling
❑ intralesional injections ❑ incision ❑ acne surgery ❑ other ______________________________

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) autorize my physician and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgement.

Just as there may be risks and hazards in continuing my present condition without treatment. there are also risks and hazards related to the performance of the surgical, medical andior diagnostic procedures planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. **I (we) also realize that the following risks and hazards may occur in connection with this particular procedure: PAIN, BLEEDING, INFECTION, SCARRING, CHANGE IN PIGMENTATION, RE-GROWTH, SLOW HEALING, CHANGE IN ANATOMICAL APPEARANCE, SKIN INDENTATION, SKIN PROTRUSION AND LOCAL NERVE DAMAGE (numbness or loss of muscle function)**

I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us). I (we) undersland that certain oomplications may result from the use of any anesthetic including respiratory problems. drug reactions. paralysis. brain damage, or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal chords, teeth, or eyes. I (we) understand that other risks and hazards resulling from spinal or epidural anesthetics include headache and chronic pain.

I (we) have been given an opportunity to ask questions of my physicians about my condition, allernative forms of anesthesia and treatment, risks of non-treatment, the procedures to use, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

Patient Signature: ____

Or other Legally Responsible Person's Signature: ______________________ **/Relationship:** ______________

Date: ________________ **Time:** ________________ **( )AM ( )PM**

Witness: ____________________ **Date:** ______________ **Time:** ________ **( )AM ( )PM**

I have explained to the patient or legal representative the disclosure and consent required for the medical, surgical, and/or diangnostic 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 ____

Consent Form

Consent to Photograph and Authorization for Use or Disclosure

Consent to Photograph:

I hereby consent to be photographed while receiving treatment at Santa Cruz Med Spa. The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

Authorization for Use and Disclosure:

I hereby authorize the use of the photograph(s) by, or disclosure of the photograph(s) to Santa Cruz Med Spa, 2030 North Pacific Ave, Unit E, Santa Cruz, CA 95060.

Purpose:

I consent to be photographed and authorize the use or disclosure of such photograph(s) to be used in my medical records, for purposes of medical teaching, or for publication in medical photographs, assist scientific, treatment, educational, public relations, marketing, news media, and charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold Santa Cruz Med Spa, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

Patient Rights:

- I may request cessation of filming or recording at any time.
- I may rescind this Authorization up until a reasonable time before the photograph is used, but I must do so in writing and submit it to Santa Cruz Med Spa.
- I may inspect or obtain a copy of the photograph whose use or disclosure I am authorizing.
- I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for any benefits.
- I have a right to receive a copy of this Authorization.

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such redisclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

I understand that I will not receive any financial compensation.

Signature

Date: _______________ Time: ________ AM/ PM

Signature: ____

(patient/representative/spouse/financially responsible party)