Lake Medical Spa- Patient Information Sheet

Name:_____ Date:_____

DOB:_____ Age:_____ Address:_____

City:_____State/Zip:_____ Referred by:_____

Cell #:_____ Occupation:_____

Email:_____ Pharmacy:_____

Do you have a history of keloid scars? Yes No have you been treated for: (please circle)
Do you have a history of skin cancer? Yes No acne depression skin disease high blood pressure
Do you sunbathe or use tanning beds? Yes No cold sores diabetes cancer
Have you ever experienced a cold sore? Yes No

YOUR HEALTH

List all medications, supplements, vitamins, diuretics, slimming tablets, blood thinner?
_____
_____

List all allergies _____
_____

Do you smoke? Yes No If so, how much/often?_____
Do you have any metal implants, a pacemaker, or body piercings? Yes No
If so, what/where?_____

How many ounces of water do you drink daily?_____ Do you use tanning bed?_____

What skin line are you currently using?_____ Stress level from 1 to 10?_____

Please rank most important to least important 1 through 6: Reduction of fine line___ Acne scars diminished___
Reduction of dry/rough___ Reduction of redness___ Reduction of brown spots/ sun damage___ Reduction of oil/acne___

Skin type: (please circle) Normal Dry/Dehydrated Oily Acne/Acne Prone Rosacea

Have you ever been under the treatment plan of a: (please circle) Dermatologist Plastic Surgeon Esthetician

Would you be interested in cosmetic surgery?____ If yes, what procedure?_____

FEMALES ONLY

Are you currently taking any contraception? Yes No
Are you pregnant or trying to become pregnant? Yes No
Are you currently breast feeding? Yes No

If getting a facial, I understand I will be receiving a medical grade treatment and irritation and redness may occur.

Signature:_____ Date:_____

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature _____

Date _____

PHOTO CONSENT

As part of my consultation, I understand that photographs may be taken to record my pre-operative and/or postoperative status and will become part of my medical records.

_____ I give my authorization for my before and after photographs to be shown to patients who are contemplating a similar procedure. Every attempt will be made to conceal my identity: however, I understand that photographs of facial procedures may not be able to conceal my identity.

_____ I **DO NOT** wish for my photographs to be shown to patients who are contemplating a similar procedure.

Patient Signature: _____