MEDICAL Aesthetics OF NORTH DALLAS

4716 Alliance Blvd. Pavilion II, Suite 270
Plano, Texas 75093
214-577-1777

Personal Profile and Health History

Last Name: _____ First: _____ Middle: _____

Street Address: _____

City, State, Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

E-mail: _____ Occupation: _____

Date of Birth: _____ Age: _____ Male: _____ Female: _____

Height: _____ Weight: _____ Ideal Weight: _____ Relationship Status: _____

Emergency Contact: _____ Contact Phone: _____

Primary Healthcare Provider: _____ Phone: _____

If under 18, person responsible for your account: _____

How did you hear about us? _____

Please specify your genetic origin: □ African American □ Asian □ Caucasian □ Hispanic □ Mediterranean □ Middle Eastern □ Native American □ Other

Females:

Are you pregnant or breastfeeding? Could you be pregnant?	Y	N
Are you planning pregnancy during course of treatment?	Y	N
During pregnancy did you develop hyperpigmentation or masking?	Y	N
Do you have regular periods?	Y	N
Are you going through menopause?	Y	N

Please list all medications – prescription, over the counter, vitamins, herbs, supplements and reason for taking them:

_____

_____

Are you using any medications purchased outside the USA?	Y	N
Are you taking any blood thinning medications?	Y	N
Are you allergic to any medications?	Y	N

If yes, please list all medications and reactions: _____

_____

Medical History (Please check all that apply)

□ Acne	□ High Blood Pressure	□ Rosacea
□ Bleeding Disorders	□ Hirsutism	□ Seizures
□ Botox / Dysport / Fillers	□ Hormone Replacement Rx	□ Shingles
□ Burns / Skin grafts	□ Implants	□ Skin Cancer
□ Diabetes	□ Kaposi's Sarcoma	□ Tattoos
□ Endocrine Disorders	□ Keloid Scars	□ Thyroid Disease
□ Epidermolysis Bullosa	□ Lupus Erythematosus	□ Vitiligo
□ St John's Wort	□ Permanent Makeup	□ Pacemaker
□ Gold Therapy	□ Polycystic Ovary Disease	□ Cold Sores / Fever Blisters
□ Heart Disease	□ Port-Wine Stain	□ HIV
□ Hemorrhoids	□ Precocious Puberty	□ Hepatitis
□ Herpes	□ Psoriasis	□ Accutane

Do you use or consume any of the following? If so, please indicate how much and how often (ex: 3x week / 1x day)

Coffee: _____ Tea: _____ Soda: _____ Water: _____ Alcohol: _____ Tobacco: _____

Please answer the following questions **Circle One**

Are you currently being treated for any medical condition?	Y	N
If yes, please explain: _____		
Have you been on antibiotics in the last 2 weeks?	Y	N
Have you ever seen a physician regarding your skin?	Y	N
Do you have any active skin diseases or infection in the area being treated?	Y	N
Do you have any skin allergies?	Y	N
Have you had skin cancer or precancerous lesions?	Y	N
Do you have psoriasis/eczema in the area to be treated?	Y	N
Are there any moles in the hair in the area to be treated?	Y	N
Are you allergic to latex, lidocaine, or any lotions?	Y	N
Have you had surgery in the area to be treated?	Y	N
Have you had any previous laser treatments/ skin treatments to the area being treated?	Y	N
If yes, please describe: _____		
Are you using a prescription Retinoid? (Retin-A, Differin, Tazorac, etc)	Y	N
Are you using glycolic/AHA home care products?	Y	N
What skin care products are you currently using? _____		
Do you or have you ever smoked cigarettes or cigars? Any tobacco use?	Y	N
Do you sunbathe?	Y	N
If yes, approximate date of last sun exposure? _____		
Are you currently using or have you used a tanning bed or self-tanner?	Y	N
If yes, approximate date of last use? _____		
Do you use a sunscreen? Summer _____ SPF _____ Winter _____ SPF _____	Y	N
Do you thread, tweeze, and use depilatories or hot wax?	Y	N
Does your skin remain discolored after healing from a cut?	Y	N

Please indicate which of the following concerns you have about your skin?

□ Aged Skin	□ Sun Damage	□ Rosacea	□ Age Spots
□ Acne	□ Enlarged Pores	□ Blackheads	□ Texture
□ Redness	□ Wrinkles	□ Whiteheads	□ Stretch Marks
□ Leg Veins	□ Hair Removal	□ Oily Skin	□ Isolated Fat Areas
□ Spider Veins	□ Unevenness	□ Dry Skin	□ Scars
□ Scarring	□ Hyperpigmentation	□ Sensitive Skin	□ Melasma

I confirm that the answers to the questionnaire are true and correct.

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Patients Parent/Legal Guardian, if Patient is Under 18

_____ Date: _____
Reviewed by Medical Aesthetician/Nurse

_____ Date: _____
Reviewed by Medical Director/Nurse Practitioner

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General Treatment Consent

_____I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied. I understand that to achieve maximum and continued results the protocol recommended by Medical Aesthetics of North Dallas should be followed.

_____I understand there are no guarantees implied as to the results of this treatment, due to many variables, such as: age, skin type, skin condition, sun damage, smoking, alcohol, environmental exposures, etc.

_____I understand that I may or may not actually see demonstrable visible results, that each case is individual.

_____I acknowledge that I have been candid in revealing any condition which might have an effect on this treatment, such as: pregnancy, medication, previous or recent skin surgery or treatment, skin cancer, cold scores/fever blisters, allergies, use of Retin-A, Accutane, Differin or hormones and recent sun/tanning bed exposure.

_____I understand that direct sun exposure, tanning beds, tanning lotions, creams or sprays are prohibited 2 weeks PRIOR to my treatment. The use of sun block protection with a minimum SPF of 30 is required, along with clothing coverage, over the treatment area(s) 2 weeks prior to treatment. I agree to refrain from skin tanning/tanning booths while I am undergoing treatment, and during the 14 days following my last treatment.

_____If I am prone to herpetic outbreaks either oral or genital, I have been advised to see my physician for a prescription or will receive a prescription from Medical Aesthetics of North Dallas.

_____I agree to refrain from any skin care treatment, cosmetic or medical, 14 days preceding and 14 days following any treatment with Medical Aesthetics of North Dallas, including filler injections and Botox/Dysport Cosmetic treatments.

_____I understand that I will not be allowed to have laser treatments during any pregnancy. My unused treatments will be placed on hold.

I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I consent to the terms o this agreement.

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Patients Parent/Legal Guardian, if Patient is Under 18

_____ Date: _____
Medical Aesthetics of North Dallas Rep

This form must be competed for all new clients and for continuing clients whose last treatment was 1 year ago or more.

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Cancellation & No Show Policy

When you call to schedule an appointment, the time is blocked off especially for you. During your appointment, we make every effort to run on time and will not allow another person to take your appointment time.

Since these appointments are set aside for you and you only, we require a 24 hour notice of cancellation so we can offer the appointment slot to someone else.

Failure to provide the required notice will result in a non-cancellation/no show fee that must be settled before another appointment can be scheduled

Fees:

A 15 - 30 minute missed appointment will be charged $25
A 45 minute missed appointment will be charged $50
A 1 hour plus appointment will be charged $100

We believe this policy allows us to provide the best possible care and customer service for all of our patients. Thank you for your understanding and compliance with this policy.

Patient has read and understands the Policy stated above.

All questions have been answered to my satisfaction.

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Patients Parent/Legal Guardian, if Patient is Under 18

_____ Date: _____
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HIPAA

In our efforts to comply with the health information privacy act, HIPAA, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please circle your choice responses to the following questions:

May we leave messages concerning your appointments/treatments with a co-worker, receptionist or secretary that regularly answers your calls?	YES	NO
May we leave messages on a voicemail at work?	YES	NO
May we leave messages on an answering machine at home?	YES	NO
May we leave messages on your cell phone?	YES	NO
May we leave messages with a spouse or significant other?	YES	NO
Is there anyone that is not listed above that we can give information to? If so, please specify.	YES	NO

_____

For any children above the age of 18, still living at home, may we discuss your appointments/treatments with your parent(s) or Guardian?	YES	NO
I would like to receive regular email updates and/or newsletters:	YES	NO

_____
Email address

You must inform us, in writing, of any changes in your directives.
This record will be kept in your file with you acknowledgement of receipt of our Notice of Privacy Practices.

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Patients Parent/Legal Guardian, if Patient is Under 18

_____ Date: _____
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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN RECEIVE ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Medical Aesthetics of North Dallas and its employees collect data through a variety of means including but not necessarily limited to intake forms, phone calls, emails, voice mails, and from the submission of our website's contact page.

Information about your financial situation, medical conditions and spa treatments/services that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to intake forms, or directly or indirectly given to us, is held in strictest confidence. We do not give out any information about our patients who receive our treatments and/or services, which is considered patient confidential, is restricted by law, or has been specifically restricted by a patient in a signed HIPAA consent form.

Information is only used as is reasonably necessary to provide you with treatments and/or services which may require communication between Medical Aesthetics of North Dallas and health care providers, pharmacies, insurance companies, and other providers.

We are legally obligated to maintain the privacy of your financial situation, medical conditions and spa treatments/services, to provide you with this Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to your protected information.

I acknowledge that I have read and understand the information provided to me in the above Notice of Privacy Practices. I feel I have been adequately informed and all of my questions have been addressed and answered to my satisfaction.

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Patients Parent/Legal Guardian, if Patient is Under 18

_____ Date: _____
Medical Aesthetics of North Dallas Rep