ReFresh Aesthetic Center provides individualized, safe and superior patient outcomes in non-surgical aesthetics.

Patient Information Form

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Ok to text apt reminders? ☐ Yes ☐ No

Ok to text promotions? ☐ Yes ☐ No

Best Contact Method: ☐ Cell ☐ Home ☐ Work

Ok to leave voicemail? ☐ Yes ☐ No

Ok to leave message with someone? ☐ Yes ☐ No

DOB: _____ Age: _____ Gender: _____

Email Address: _____

Ok to email apt reminders? ☐ Yes ☐ No Ok to email Promotions? ☐ Yes ☐ No

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about our clinic?

☐ ReFreshAestheticCenter.com
☐ Internet Search Engine
☐ Social Media (FaceBook, Twitter, Instagram, etc)
☐ Other: _____
☐ Patient Referral: _____
☐ Friend: _____
☐ MD/RN/NP Referral: _____
☐ Aesthetician/Hairstylist: _____

What are your primary cosmetic goals/concerns? _____

Are you planning to attend a special event (wedding, reunion, other)? If so, when? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other:

Cell Phone: _____ Other Phone: _____

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe: _____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Weight:
Height:

	Have you or do you still have:	No	Yes	Description
3.	Arthritis	☐	☐	
4.	Asthma	☐	☐	
5.	Autoimmune Disorders	☐	☐	
6.	History of Bell's Palsy	☐	☐	
7.	Emphysema	☐	☐	
8.	High Blood Pressure	☐	☐	
9.	Heart Trouble (heart attack/arrhythmias/mitral valve prolapse)	☐	☐	
10.	Hepatitis or Liver Trouble	☐	☐	
11.	Kidney Trouble	☐	☐	
12.	Diabetes	☐	☐	
13.	Epilepsy or Seizures	☐	☐	
14.	Neuromuscular function disorders (Myesthenia Gravis, Lamber Eaton Syndrome)	☐	☐	
15.	Problem Scarring	☐	☐	
16.	Stroke	☐	☐	
17.	Thyroid Disorders	☐	☐	
18.	History of OCD, anxiety, bipolar, panic or body image disorders	☐	☐	
19.	Have you ever been under mental health care?	☐	☐	
20.	Are you currently under mental health care?	☐	☐	
21.	Bleeding tendencies	☐	☐	
22.	History of cold sores/fever blisters	☐	☐	
23.	Others Not Listed:			

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much?
2. Do you drink? ☐ No ☐ Yes, how much?
3. Do you have children? ☐ No ☐ Yes, how many?

Section IV: Previous Cosmetic Surgery and Non-Surgical Aesthetic Procedures

	Have you done any of the following procedures?	No	Yes	Description
1.	Cosmetic Surgery	☐	☐	
2.	Botox/Dysport/Xeomin	☐	☐	

3.	Dermal Fillers (Juvederm, Voluma, Volbella, Vollure, Refyne, Defyne, Silk, Sculptra)	☐	☐
4.	Kybella	☐	☐
5.	Laser/Light Treatments (Hair removal, BBL, resurfacing)	☐	☐
6.	Skin tightening/Body contouring	☐	☐
7.	Facial Peels	☐	☐
8.	Microdermabrasion/Dermaplane	☐	☐
9.	Spider Vein Treatments	☐	☐
10.	Others Not Listed		

Section V: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

Section VII: Skin Care Regimen

Skin Type: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Indian ☐ Other:

Products you currently use:

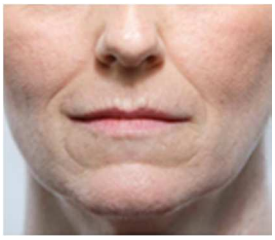
Cleanser/Toner: _____ Growth Factor: _____
Antioxidant: _____ Hydroquinone/Lightener: _____
Hydrator: _____ Eye Cream: _____
Moisturizer (AM): _____ Moisturizer (PM): _____
Retinol/Glycolic: _____ SPF: _____
Other: _____ Makeup Brands: _____
How much UV exposure do you get? (sun, tanning beds, driving, etc.): _____

Interest Questionnaire

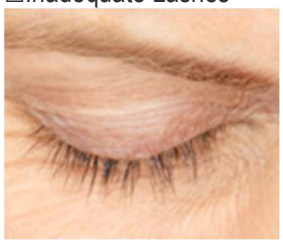
Besides the purpose of today's visit, please tell us what you would like to hear about. Select all that apply:

☐Skin care advice

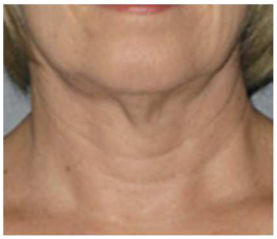
☐Fine Lines/Wrinkles



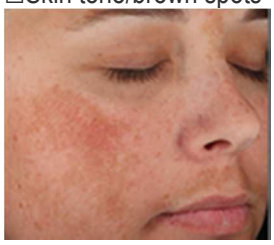
☐Inadequate Lashes



☐ Neck Wrinkles

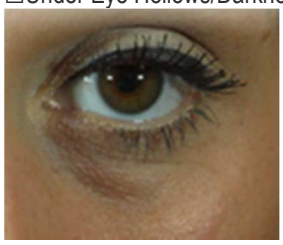


☐Skin tone/brown spots

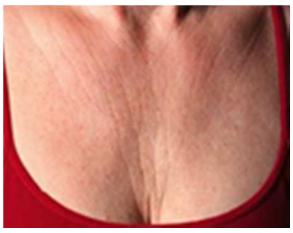


☐Forehead wrinkles

☐Under Eye Hollows/Darkness



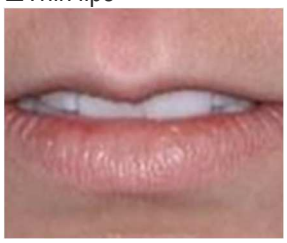
☐ Decollate Wrinkles



☐Skin texture/acne scars

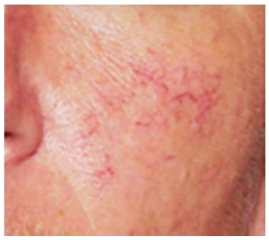
☐Crow's Feet Wrinkles

☐Thin lips

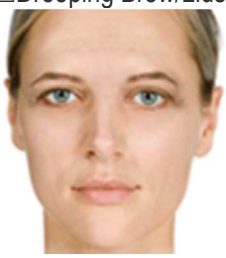


☐ Under Chin Fullness

☐Blood Vessels/Rosacea

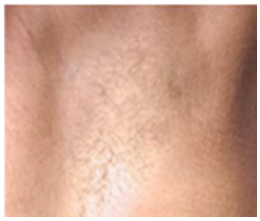


☐Drooping Brow/Lids



☐Facial droopiness

☐ Unwanted hair



Please check any of the services that you would like more information on:

☐Dermaplane ☐BBL™ Photofacial ☐Botox®/Dysport®
☐HydraFacial MD® ☐Microlaser Peel®/Profractional™ ☐Allergan Fillers (Voluma®, Volbella®, Vollure®, Juvederm®)
☐PCA Chemical Peels® ☐Vascular ClearScan YAG™ ☐Galderma Fillers (Restylane® Family, Sculptra®)
☐PCA Body Peels® ☐Sclerotherapy ☐Kybella® (deoxycholic acid)
☐Dermaglow Microderm ☐ThermiSmooth Face/Body® ☐Latisse®
☐Facials ☐SkinPen® Microneedling ☐Medical Grade Skin Care (SkinMedica®, SkinCeuticals®, Avene®, Revision®)
☐Waxing/Tinting ☐Surgical Consultation ☐Jane Iredale Cosmetics
☐Lumenis LightSheer® Hair Removal ☐Other: _____

Cancellation & Missed appointment Policy

We want to thank you for choosing us as your health care provider. In order to give you and all our clients the best possible care, we request that you review our policy regarding missed and/or cancelled appointments.

A missed appointment is when you fail to show up for an allotted appointment time, without a cancellation notice of at least 24-hours. These appointments will be confirmed two (2) days in advance with a phone call, email or text message from our office.

I acknowledge that if I miss an appointment or do not give 24 hours' notice of cancellation for an appointment at ReFresh, I will incur a $75 to $100 fee.

Signature of Patient Printed Name Date

Patient Photograph Consent

Explanation

This consent form authorizes my provider to take before and after treatment photographs for the purpose of documenting progress and results of specific treatments. Your photos will be used as a part of your medical record.

Consent

I understand the photographs taken of me shall be used for the purpose of medical records. I hereby authorize and give permission for pre and post treatment photos to be taken.

Signature of Patient Printed Name Date

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature of Patient	Printed Name	Date