



## PATIENT INTAKE FORMS

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_  
(street) (city) (state) (zip code)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_  
(Name) (Phone Number)

### **CANCELLATION/NO SHOW POLICY:**

By signing below, I agree with the office's cancellation/no show policy. This policy states that if I no show or cancel within 24 hours of my appointment, I will have to pay a **\$50 fee** and risk losing one treatment from a pre-purchased package. I will receive this fee via \_\_\_\_\_ (indicate preferred means of receipt). If I don't pay before the due date, I will be sent to collection. If I don't sign below, I won't be able to get treated.

Patient/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **HIPAA INFORMATION:**

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. Patient filed may be stored in a closed based HIPAA compliant server. And will not contain any coding which identifies a patient's condition or information which is not 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, procedure records, protected health information and other documents or information.

Patient/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **PAYMENT INFORMATION:**

All charges are due at the time of service. If surgery is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to surgery. All professional services rendered are charged to the patient. The patient is responsible for all fees. It is customary to pay for services when rendered unless other arrangements have been made in advance. Surgery and non-surgical procedures come with no warranty (guaranteed or implied) of any certain result. Once services are rendered or products sold, we do not issue refunds.

Patient/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **GENERAL CONSENTS:**

- I consent to medical test and procedures in the office as may be deemed necessary for my care.
- I consent to receiving information from your practice via E-Mail Text Mail Phone

## PATIENT HEALTH HISTORY FORM

What is your skin care goal?

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When you look in the mirror, what bothers you the most?

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Do you have any health problems or medical conditions? Please list:

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Please list ALL allergies (medication, food, pollen, etc.) you may have and describe your reaction:

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Please list ALL medications (prescription, over the counter, creams, skin care, herbs, etc.) you take:

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Are you currently using or have you used any of the following medications within the last 6 months?

- Accutane     Retin-A     Tretinoin     Isotretinoin     Tetracycline     Griseofulvin     Ciprofloxacin  
 Naproxen     Amiodarone     Thiazides

**Please check the following:**

- |   |  |
|---|--|
| Complications from any laser or light treatments?             | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Complications from any cosmetic procedures?                   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Form thick or raised scars from cuts or burns?                | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hyperpigmentation (darkening of the skin)?                    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hypopigmentation (lightening of the skin)?                    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Recent use of self tanning lotion, tanning or sun exposure?   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Any active infection?   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Are you pregnant?   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Any major illness or hospitalization within the last 5 years? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Any alternative medical procedures?                           | <input type="checkbox"/> No <input type="checkbox"/> Yes |

**Interest Questionnaire:**

- Botox/ Dysport/Xeomin (crow's feet, forehead, between eyebrows, around mouth)
- Filler: Juvederm Ultra, Juvederm Ultra Plus, Voluma, all Restylane fillers (lips, cheek, smile lines)
- Kybella (dissolves fat under chin)
- Full Body Cosmetic Surgery (breast augmentation, breast reduction, breast lift, tummy tuck + more)
- Face + Neck Cosmetic Surgery (nose job, upper + lower eyelids, face lift, neck lift, eyebrow lift + more)
- Laser: hair removal, vein removal, facials, IPL (intense pulsed light)
- Chemical peels: Illuminize peel, Vitalize peel, Rejuvenize peel, Polish Peel (Only @HWH), Jessner Peel
- Permanent Makeup: eyebrows, eyeliner, lip liner, microblading
- Microneedling: acne, scars, stretch marks, anti-aging, hyperpigmentation, hair growth
- PRP: Protein Rich Plasma treatments: filler, topical, hair growth
- Skin care: Skin Medica Skin Care Line + Huntington Women's Health Skin Care Line
- Arnica: Reduces bruising, swelling + Pain from injections \$12.99.... Ask the front staff!