PRECISION
AESTHETICS

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## NEW PATIENT INTAKE FORM // AESTHETIC AND LASER TREATMENTS

*This form is to help us treat you better. Please keep us updated on any changes in your health or medications. Always feel free to ask us any questions that may arise. This form is confidential.*

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Sex: Male Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____

**What concerns bring you in today? (please circle all that apply)**

Forehead lines
Large pores
Redness or vessels
Skin texture
Irregular pigmentation
Acne
Acne scars
Dull complexion
Brown spots
Tattoos
Skin tone
Hair growth
Freckles
Skin tags
Warts
Crow's feet lines
Frown lines
Lines around mouth and nose
Age spots
Crepey skin

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Are you pregnant? Y__N__ Nursing? Y__ N __ Are you planning on becoming pregnant? Y__N__

Are you currently taking ACCUTANE or have you taken this in the past 6 months? Y__ N__

Are you currently using glycolic acid or Retin A?

_____

What is your daily skincare regimen?

_____

_____

Do you have any active skin diseases or infections in the area to be treated? Y___ N ___

If yes, please describe: _____

**Past Personal Medical History: (please circle all that apply)**

Hepatitis B or C
Cold Sores
Vitiligo
Hormone Replacement
Psoriasis
Connective Tissue Disorder
Metal implants
Acne
Bleeding Disorder
Blood Clots
Cancer
Keloid Scars
Port-Wine Stain
Actinic Keratosis
Squamous Cell Carcinoma
Non-healing Sores

Shingles
High Blood Pressure
Permanent Makeup
Eczema
Rosacea
Diabetes
Thyroid Disorder
Serious Skin Infection
Heart Disease
Irregular Heartbeat
Pacemaker
Lupus
Melasma
Seborrheic Keratosis
Melasma
Suspicious Moles

Genital Herpes
Melanoma
Hirsutism
Epidermolysis Bullosa
Kaposi's Sarcoma
HIV/AIDS
Multiple Sclerosis
Seizure Disorder
Stroke
Thyroid Disorder
Burns
PCOS
Adopted
Undiagnosed Lesions
Basal Cell Carcinoma
Fainting

Other: _____

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Do you smoke? Y___ N____

Have you recently been tanning or had sun exposure that changed your skin color? Y___ N __

Are you using any self tanning lotions or treatments? Y___ N ____

Are you currently doing any of the following:
Electrolysis? _____
Tweezing? _____
Laser Hair Removal? _____
Waxing? _____

Allergies or sensitivities to medications, topical preparations, iodine, or latex?
_____

Other Allergies?
_____

Current medications and supplements:
_____
_____

Current topical medications:
_____

Have you had any previous laser treatment or other skin treatments to the area being treated?
Describe: _____

Please list any adverse reactions to previous cosmetic treatments:
_____
Have you had any permanent cosmetic tattooing in the area to be treated? Y ___ N___

Have you ever seen a Dermatologist or Plastic Surgeon for your skin? Y___ N___
If yes, please explain:
_____

Previous surgeries?
_____

Have you been exposed to the sun in the past 4-6 weeks? Y ___ N ___; if yes, when?

Do you use tanning beds? If so, date of last use? _____

Do you use sunscreen on a regular basis? _____

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Do you exercise on a regular basis? _____

Do you wear contact lenses? _____

How much water do you normally consume daily? _____

**What services are you most interested in?**

_____

_____

## Fitzpatrick Skin Typing *What best describes you?*

| | |
|---|---|
| ☐ Type 1 | Very white or freckled skin, always burns with sun exposure (very fair: often in people with red or blonde hair and blue eyes) |
| ☐ Type 2 | White skin, usually burns with sun exposure (fair, often in people with red or blonde hair & blue, green or hazel eyes) |
| ☐ Type 3 | White or olive skin tone, sometimes burns with sun exposure (fair, seen in people with any hair or eye color) |
| ☐ Type 4 | Brown skin, rarely burns with sun exposure (common in people of Mediterranean descent) |
| ☐ Type 5 | Dark brown skin, very rarely burns with sun exposure (common in people of Middle-Eastern descent) |
| ☐ Type 6 | Black skin, never burns with sun exposure |

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## Patient Consent to Treatment

Name: _____ DOB: _____ Age: _____ Date: _____

I, the undersigned, do hereby request and consent to an evaluation and treatment by Precision DPC and Precision Aesthetics and its staff "Practice". I wish to rely on the practice to exercise judgment for my best interest, the below named patient, during the course of treatment. I will inform the Practice of any sensitive areas or adverse conditions that I may have had prior to, during or after treatment. I intend this consent to cover the entire course of treatment. I understand that any questions I may have regarding the potential side effects, complications, treatment or treatment area may be directed to the attending Practice staff member during my evaluation and course of treatment.

I understand that the practice of medicine and laser skin care treatments is not an exact science. I further understand and accept that fees are paid for performance of the aforementioned services only, and not for guaranteed results. I acknowledge by my signature below that although a good outcome is expected, and a reasonable effort has been made to establish realistic expectations, there cannot be any warranty, expressed or implied, as to the results that may be obtained.

I request and consent to be transported by Practice staff and/or emergency medical services to a hospital or emergency medical facility in the event of a medical emergency during the course of my treatment at the Practice.

_____ _____

Printed Patient Name Date Signature of Patient Date

_____ _____

Practice Representative Name Signature of Practice Representative

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## Patient Photography Consent Form

Name: _____

DOB: :_____ Age: :_____

I, as the patient identified above or the legal representative of such patient ("Patient") consent to have photographs, videotapes, digital or audio recordings, and/or images of the "Patient", and any other method to reproduce or edit such Patient's likeness or image now known or hereafter developed (collectively, "Photography"), taken by Precision Direct Primary Care & Aesthetics and its staff (collectively "Practice"). I understand that such Photography will be recorded to document and assist with the Patient's care and to assist with Practice's health care operations.

I understand that the Photography or a portion of the Photography may become part of my medical record and therefore be protected, used and/or disclosed in accordance with Practice's Notice of Privacy Practices I further understand that Practice will own the Photography and I will not receive any payment for such Photography but that I will be allowed to access or view the Photography or to obtain copies of any portion of the Photography that becomes part of my medical record.

I have read this consent in its entirety and agree to be bound by all its terms and conditions as described above. I acknowledge and agree that I have been given the opportunity to ask any questions and had all my questions answered to my satisfaction.

_____ _____

Printed Patient Name Date Signature of Patient Date

_____ _____

Practice Representative Name Signature of Practice
Representative

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# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act (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 (where applicable) who may be involved in that treatment, directly or indirectly.

- Obtain payment from third party payers (if applicable).

- Conduct normal healthcare operations such as quality control and physician certifications.

I acknowledge that I have read your *Notice of Privacy Practices.* I understand that Precision DPC and Precision Aesthetics has the right to change its *Notice of Privacy Practices* when necessary and that I may contact Precision DPC and Precision Aesthetics at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed in order to carry out treatment, payment, or health care operations.

Patient Name Printed: _____

Patient Signature: _____

Date: _____ / _____ / _____