PATIENT PROFILE/MEDICAL HISTORY

We are a medical-spa, a complete and accurate medical history for consultation and treatment is required. Please Print Clearly! We notify appointments by phone and e-mail.

Today's Date:

PATIENT INFORMATION

Name (First, Middle, Last):	E-mail Address:

Date Of Birth:	Please indicate what procedure you are having performed today.	Sex:	Age:
	☐ Laser Hair Removal ☐ General Consult ☐ Nail Fungus ☐ Botox ☐ Skin Tightening & Cellulite Reduction ☐ Permanent Makeup ☐ Dermal Fillers ☐ Lipotropic/B-12 Shot ☐ Teeth Whitening ☐ Skin Care ☐ hCG Program ☐ Sclerotherapy ☐ Laser Facial Treatment ☐ Other:_____	☐ M ☐ F	

Street address:	Cell Phone:	Home phone :

P.O. Box:	City:	State:	Zip Code:

Emergency Contact:	Name:	Phone:

How were you referred to us?

☐ Friend (please tell us who)_____

☐ Internet (which search engine)_____

☐ Magazine/Publication (which one)_____

☐ Drive By_____

☐ Other(please explain)_____

What procedures are you most interested in for your next visit? ☐ Laser Hair Removal ☐ Laser Facial Treatments ☐ Body Contouring ☐ Skin Care

PATIENT HISTORY

List Hospitalizations for illness, operations, and outpatient procedures accidents. Include cosmetic surgeries:

Reason:	Year:	Reason:	Year:

Have you had any form of cosmetic surgery, minor cosmetic procedures or implants? ☐ Yes ☐ No When & Type:

Have you ever had laser resurfacing?	Have you had Botox injections?	Have you had collagen/dermal filler injection(s)?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
When, Type, & Reaction:	When & Frequency:	When & Type:

Allergies ☐ Yes ☐ No

☐ Adhesives ☐ Mushrooms
☐ Milk ☐ Eggs
☐ Citrus ☐ Apples
☐ Aspirin ☐ Hydroquinone
☐ Latex ☐ Alcohol based products
☐ Penicillin ☐ Sulfa
☐ Codeine ☐ Other: _____

Page 2

Have you ever had or have been treated for: Please mark all that apply.

☐AIDS/ARC ☐Alcohol Addiction ☐Shortness of Breath ☐Frequent Headaches
☐Cancer ☐Bone/Joint Deformity ☐Back Problem/Pain ☐Tendonitis
☐Epilepsy ☐Diabetes ☐Head Injury ☐Varicose Veins
☐Neuritis ☐Allergy/Hay Fever ☐Drugs ☐Eye Injury/Disease
☐Dizziness/Fainting ☐Rheumatism/Arthritis ☐MitralValve Prolapse ☐High Blood Pressure ☐Bleeding Problems
☐Tuberculosis
☐Skin rash/Disease ☐Asthma ☐Heart Trouble
☐Swollen/Painful Joints ☐Wheezing ☐Phlebitis of vein
☐Head Injury ☐Other:_____

List all prescription and non-prescription medication you are currently taking or have recently take:

☐Accutane-when stopped:
☐Cold/Allergy Medication
☐Insulin/Diabetic Meds
☐Tranquilizers/Anti-depressants
☐Antibiotics

☐Vitamins
☐Tazorac
☐Blood Pressure
☐Thyroid
☐Blood Thinners (i.e. Coumadin, Plavix)
☐Heart
☐Anti-inflammatories (ie Ibuprofen, Motrin ,Aleve)
☐Regular/Baby Aspirin (daily)

Have you ever seen a dermatologist or other physician for your skin?

☐Yes ☐No

If yes please describe:

Do you drink alcohol?

☐No ☐1-2week
☐3-5week ☐5+week

Do you smoke?

☐No ☐I quit____years ago
☐Less than 1pack a day
☐1 pack a day ☐More than 1 pack/day

Do you wear contacts?

☐Yes ☐No

Are you currently under a Doctor's care?

☐Yes ☐No

If yes,
Doctor's name:_____
_____
For what:_____
_____
_____

WOMEN ONLY:

Are you pregnant? ☐Yes ☐No
Due Date:_____
Date of last period:_____

When you go to the Dentist:

Do you require antibiotics be use
☐Yes ☐No

Do you require extra numbing medications?
☐Yes ☐No

Have you ever had a "cold sore"? ☐Yes ☐No
Frequency:_____
If yes, have you ever been prescribed an anti-viral medication such as Zovirax or Acyclovir?
☐Yes ☐No

Previous Facial Procedures:

I have had the following treatments in the past 6 months:

☐Facial/Peel
☐Microderm
☐Wax
☐Electrolysis
☐Depilatories

Skin Description
Do you experience:

☐Acne ☐Hypo-Pigmented (lack of pigment)
☐Eczema ☐Hyper-Pigmented (excess pigment)
☐Rosacea ☐Melasma (pregnancy mask)
☐Sun- damage ☐Psoriasis

(Continue on next page)

Page 3

Sun History and Lifestyle:	When you are in the sun, do you: ☐Easily Burn ☐ Sometimes Burn ☐Rarely Burn	How often are you in the sun: ☐1-2x/month ☐1-2x/week ☐3-4x/week ☐Almost daily	How often do you use sunscreen? ☐Daily ☐Only when going outside ☐Rarely use
What type and strength of sunscreen do you use?		Do you work primarily inside: ☐Yes ☐No	Occupation:
In the past have you neglected to use sunscreen? ☐Yes ☐No		Do you use any of the following products: ☐Vitamin C ☐Exfoliants ☐Retinol ☐Hydroquinone	
Have you or anyone in your family had skin cancer? ☐Yes ☐No		If yes, describe:	Are you in the habit of going to tanning booths? ☐Yes ☐No

Desired Improvements:	Current appearance/problems/goals that brought you to Radiance Medspa:	☐Wrinkles ☐Scarring ☐Pigmentation/Complexion	☐Skin Laxity ☐Excess Fat ☐Acne ☐Enlarged Pores
Desired Improvements: What non-surgical cosmetic medical procedures would you like to learn more about?		☐Botox ☐Facials ☐Photofacials ☐Dermal Fillers (Restylane, Perlane) ☐IPL Permanent Hair reduction	☐Fractional Laser Resurfacing ☐Exfoliating Peels ☐Microdermabrasion ☐Thermage Skin Tightening ☐Smartlipo Ultra (lipolysis)
FOR OFFICE USE ONLY:	Fitzpatrick Scale:	☐I- Always burns, never tans ☐II- Always burns, sometimes tans ☐III-Sometimes burns, always tans ☐IV-Rarely burns, always tans ☐V- Brown, moderately pigmented skin ☐VI-Black Skin	

_____ _____

Patient Signature **Date**

_____ _____

Clinician Signature Date

Notice and Acknowledgment of Privacy Policy and Procedures

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), Radiance MedSpa may not use or disclose your personal health information without your authorization.

THE PRACTICE HAS POLICIES AND PROCEDURES TO COMPLY WITH HIPAA LAW; EVERY ATTEMPT HAS BEEN MADE TO KEEP THE PROCESS FOR PATIENTS AND STAFF AS EFFICIENT AS POSSIBLE. IT TAKES EFFORT AND COOPERATION TO PROCESS REQUIRED TASKS. THE REQUIREMENTS ARE EXTENSIVE AND TAKE TIME.

All patients are presented with certain notices and must sign certain forms and consent forms. Depending on the course of treatments, some patients may be required to sign additional forms. The following is a summary of the most common notices and forms.

Notice of Privacy Practices: This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Authorization for Use or Disclosure of Protected Health Information: The Practice may not use or disclose your health information for purposes other than treatment, payment or health care operations, without your authorization. Your signature on this form indicates that you are giving permission to the people listed on the form, for the use and disclosure of health information listed on the form, for the purposes on the form, to the people/organizations listed on the form. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

Complaint: You have the right to complain about the Practice privacy policies, procedure, or actions. The Practice will not engage in any discriminatory or other retaliatory behavior against you because of a complaint.

Request to Amend Protected Health Information: You have the right to that health information that pertains to you be amended if you believe that it is incorrect or incomplete. The Practice will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures.

Request for Inspection of Protected Health Information: You have the right to request the opportunity to inspect and copy health information that pertains to you. The Practice will evaluate your request and will either grant it or explain why the request will not be granted. In the event that your inspection request is not granted, you may request that the decision be reviewed by someone other than the person who denied the request.

Request for Accounting the Disclosures of Protected Health Information: You have the right to request an accounting of disclosures of health information that pertains to you.

Confidential Channel Communications Request: You have the right to request that communications concerning your personal health information be made through confidential channels. The Practice will do its best to accommodate all reasonable requests.

Designation of Personal Representative: You have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By making this request, you are informing the Practice of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I have received and read the above Notice of Privacy Policy and Procedures and that I've had any questions regarding this notice answered to my satisfaction.

_____	_____	_____
Patient /Patient Representative Signature	**Print Name**	**Date**
_____	_____	_____
Radiance MedSpa Representative Signature	Print Name	Date

Acceptance of New Radiance
Late Arrival Policy and Cancellation Policy

Dear Valued Client,

This document clearly outlines our **Late Arrival Policy and Cancellation Policy**. Please do not sign this document until you have read it thoroughly.

In order to continue to provide outstanding service and competitive pricing for services, we ask clients to adhere to the policies below:

1. We value your time, if you have arrived more than 10 minutes late for an appointment, you may not be able to have the full services you originally scheduled for. This will assist us in ensuring that all patients are seen on a timely basis.

2. Should you arrive 15 minutes or later for your scheduled appointment, you may be asked to wait for an opening or be rescheduled for your service.

3. If you need to cancel or reschedule an appointment this must be done with a minimum of 24 hours prior to your scheduled appointment.

We understand how hectic schedules can be and sometimes you may need to reschedule or cancel an appointment. We are happy to assist you with that request and expect that you do so in accordance with our cancelation policy.

Our office hours are 8:30A.M -7:00P.M, Monday through Thursday, 9:00A.M-9:00P.M Friday and Saturday, and 12:00P.M-6:00P.M on Sundays. An associate can help you reschedule any appointment during open hours, or you may leave a message on our voicemail to cancel an appointment. ***Our voicemail will date and time-stamp your call and we will return your call as soon as it is received.***

The Cancellation Policy for all appointments requires a **minimum of 24 hours prior notice to your scheduled appointment to avoid a $50 cancellation fee**. We kindly ask you to help us in our efforts in providing outstanding customer service and allow all clients to make appointments that fit their busy schedules.

Client Signature: _____ **Date**: _____