

Client Information and Medical History

Name _____ Date ____/____/____
DOB ____/____/____ Age _____ Height _____' _____" Weight _____ [] Male [] Female
Address _____ City/State _____ Zip _____
Home Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____ Email _____
Emergency Contact _____ Phone _____ - _____ - _____ Relation _____
How did you hear about us? _____

Have you ever received any of the following injections: (Check all that apply)

[] Botox [] Dysport [] Restylane [] Perlane [] Collagen [] Radiesse [] Juvederm

[] Other _____

Have you ever had any of the following treatments? (Check all that apply)

[] Laser Resurfacing [] Glycolic/AHA Peel [] Phenol Peel [] TCA Peel [] Photo Facial
[] Laser Hair Reduction [] Laser Vein Reduction [] Microdermabrasion [] Sclerotherapy [] Tattoo Removal
[] Permanent Makeup [] Facelift [] Liposuction [] Other Cosmetic Surgery _____

Do you regularly use tanning salons or sun bathe? _____ How often? _____

What procedures are you interested in?

- [] **Laser Hair Reduction** Reduce unwanted facial and/or body hair
- [] **FotoFacial** Reduce Hyperpigmentation, sun damage, redness and fine lines while improving skin texture
- [] **Botox®** Reduce fine lines and wrinkles
- [] **Facial Fillers** Fill wrinkles, folds and lines with injected dermal fillers
- [] **Laser Vein Reduction** Reduce small facial and leg veins
- [] **Microdermabrasion** Improve skin texture and reduce the appearance of acne, fine lines and superficial pigmentation
- [] **Chemical Peel** Reduce fine lines, reveal smoother skin and improve uneven skin tone
- [] **Skin Tightening** Stimulate collagen plumping and dermal thickening, reduce fine lines and wrinkles
- [] **Body Contouring** Reduce the appearance of cellulite and reduction of thigh circumference and localized fatty areas using VelaShape technology

Complaints

What are your general complaints:

[] Cellulite [] Body Fat [] Facial Fat [] Spider Veins [] Varicose Veins
[] Broken Capillaries [] Thin Lips [] Loose body skin [] Loose facial/neck skin [] Facial hair
[] Body hair [] Wrinkles/lines [] Acne [] Age spots [] Hyperpigmentation
[] Sun damage [] Pre-cancerous cells [] Moles [] Rosacea [] Spots
[] Scars [] Fatigue [] Premature Aging [] Poor circulation [] Other _____

Aesthetica

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Medical History

Are you currently under the care of a physician or Dermatologist? _____

List all medications/herbal remedies your are currently taking _____

List all known food/medication allergies _____

List and date all surgeries _____

Do you wear contact lenses?	<input type="checkbox"/> Y <input type="checkbox"/> N	Are you taking antidepressants?	<input type="checkbox"/> Y <input type="checkbox"/> N type _____
Are you sensitive to cold?	<input type="checkbox"/> Y <input type="checkbox"/> N	Are you taking hormones?	<input type="checkbox"/> Y <input type="checkbox"/> N type _____
Do you bruise easily?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you take a blood thinner?	<input type="checkbox"/> Y <input type="checkbox"/> N type _____
Frequent bladder infections?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you drink caffeine?	<input type="checkbox"/> Y <input type="checkbox"/> N frequency _____
Do you suffer constipation?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you smoke?	<input type="checkbox"/> Y <input type="checkbox"/> N frequency _____

Have you ever used Accutane? Y N when? _____
 Have you ever used Renova, Differin, Tazorac or Retin-A? Y N Last Dose? _____

How do you prefer your massage pressure? Firm Medium Light
 How much water to you drink daily? _____ oz.

Have you ever been diagnosed or treated for any of the following? (Check all that apply):

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Polio | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Keloid scars | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Lupus | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Nerve Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Seizures | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> Goiter | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Suicide Attempt | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Vaginal Infection |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tumors | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Cellulitis | <input type="checkbox"/> HSV | <input type="checkbox"/> Muscular Disorder | <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> problems with anesthesia |

FOR OUR FEMALE CLIENTS

Are you using contraception? _____ Are you currently pregnant or nursing? _____ Are you trying to become pregnant? _____

Are there any other medical conditions you have been diagnosed with or are being treated for? Y N

Explain _____

Authorization and Disclosure

I hereby authorize Aesthetica Medical spa to take to use pre-operative, intra-operative and post-operative photographs for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, for the purposes of medical education, lay publication, or during lectures to medical or lay groups. Every attempt will be made to conceal each patient's identity. I understand I will not be entitled to monetary payment or any other consideration as a result of any use of these images. I have fully disclosed my medical history and have completely and accurately answered all health related questions. I acknowledge Aesthetica Medical spa's cancellation policy: Twenty-four (24) hour notice is required for all appointments. I understand that if I fail to give 24 hours notice or fail to appear for appointment, a \$35.00 service charge may apply. I also understand a \$35.00 processing fee will be added to any returned checks.

Signature _____

Date _____

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The Fitzpatrick Skin Type Scale

This chart helps determine your true Skin type which lets us determine the right amount of energy to treat you with our lasers.

Genetic Disposition

Score	0	1	2	3	4
Your natural eye color?	Light blue, green, or gray	Blue, gray or green	Blue	Dark Brown	Brownish Black
Natural color of your hair?	Sandy, red	Blond	Chestnut/ Dark Blond	Dark Brown	Black
Color of your non-exposed skin	Reddish	Very pale	Pale with beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	none

Reaction to Sun Exposure

Total score for genetic disposition: _____

Score	0	1	2	3	4
What happens when you stay too long in the sun?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns sometimes, followed by peeling	Rarely burns	Never burn
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

Tanning habits

Total score for reaction to sun exposure: _____

Score	0	1	2	3	4
When did you last expose your body to sun or tanning booth/cream?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than one month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total score for tanning habits: _____

Summary

Add up the total scores for each section for your Skin Type Score to give you a better evaluation of your skin type.

_____ Total score for Genetic Disposition

_____ Total score for Reaction to Sun Exposure

_____ Total score for Tanning Habits

_____ Skin Type Score

Your Fitzpatrick Skin Type:

Your Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V – VI

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PATIENT CONSENT

I consent to and authorize Aesthetic to perform treatments on me which may include but are not limited to Laser Hair Removal, Photo Rejuvenation, Co2 skin resurfacing, Fraxel skin resurfacing, Laser skin lightening, laser skin tightening, Laser Tattoo removal, or Laser Vein Removal. The following are potential side effects that may occur with any laser treatment we offer here at Aesthetica.

Reddening, mild burning, temporary bruising or blistering, hyper-pigmentation (darkening) and hypo-pigmentation (lightening) have also been noted after treatment. These conditions usually resolve within 3-6 months, but **permanent color change while rare can occur**. Avoiding sun exposure before and after the treatment reduces the risk of color change, and must be avoided completely 2 weeks before and 2 weeks after any laser procedure.

3. Infection: Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.

4. Bleeding: Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary.

5. Allergic Reactions: In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines.

6. I understand that exposure of my eyes to light could harm my vision. I must keep the eye protection goggles on at all times.

7. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyper-pigmentation. Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release Aesthetica Medical Spa, Medical staff and from all liabilities associated with the above indicated procedure.

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

- As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide to health care that is in your best interest.
- We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.
- You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review the privacy notice, to request restrictions and revoke consent in writing after you have reviewed the privacy notice.

Thank you for taking the time to read and understand these policies. Your signature below represents an understanding of these policies and acceptance of financial responsibility.

Patient

Parent or Legal Guardian

Date

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ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

ARBITRATION AGREEMENT

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE BACK TO VIEW ALL ARTICLES OF THIS CONTRACT.

PATIENT SIGNATURE **X**

(Or Patient Representative) Print

Sign

(Indicate relationship if signing for patient)

OFFICE SIGNATURE **X**

X Dr. Kimball Crofts and Aesthetica Medical Spa

Aesthetica