VEIN & LASER INSTITUTE

Cosmetic - Health History Form

Patient Name: _____ **DOB:** _____ **Patient #** _____

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

Home Phone: _____ **Cell Phone:** _____ **Preferred #:** Home or Cell (circle)

Email: _____ **May we add you to our email list?** **Yes** **No**

Referred by: _____ **May we add you to our texting list?** **Yes** **No**

There exists a risk if our staff is not aware of the general health and medical background of a patient, and in order to provide you with the most appropriate treatment, we need you to complete the following questionnaire and please notify us of any changes that occur. All information is strictly confidential.

Health Assessment:

→ Please list all surgeries that you have had with the date you had the surgery:

_____

_____

→ Do you have any allergies? **Yes** **No**

If yes, please indicate them: _____

→ Are you currently taking medications, or vitamins? **Yes** **No**

If yes, please indicate them: _____

→ Do you smoke? **Yes** **No**

→ Do you drink alcohol? **Yes** **No**

→ Are you pregnant or trying to get pregnant? **Yes** **No**

→ Are you currently breast feeding? **Yes** **No**

→ Do you bruise easily? **Yes** **No**

→ Do you have a history of cold sores? **Yes** **No**

→ Do you (or family) have a history of atypical moles, vitiligo, developing keloids, melanoma, or skin cancer? **Yes** **No**

If yes, please circle which and explain: _____

→ Do you use self-tanners (creams, spray-on tanners) or visit a tanning booth? **Yes** **No**

If yes, how often & when was the last time? _____

→ Have you ever had an adverse reaction to a laser treatment or other cosmetic treatments? **Yes** **No**

If yes, what kind of reaction and what was it from? _____

→ In areas that you're interested in having treated for hair removal here at the Vein and Laser Institute, have you used any type of hair removal methods in the past 3 weeks? (waxing, plucking, tweezing, etc.) **Yes** **No**

→ Have you (or family) ever had an unusual reaction/problem with local, topical, or general anesthesia? **Yes** **No**

If yes, please explain: _____

Please **CIRCLE** the skin type on the Fitzpatrick Skin Type Classification Scale
that best suites you based on your complexion and what happens to your skin in the sun.

Skin Type	Skin Color	Characteristics
I	White; very fair; red or blonde hair; blue eyes; freckles	Always burns, never tans
II	White; fair; blonde/light brown hair; blue, hazel, or green eyes	Usually burns, tans with difficulty
III	Cream white; fair with any eye color or hair color; very common	Sometimes mild burn, gradually tans
IV	Brown; typically, Mediterranean Caucasian skin	Rarely burns, tans with ease
V	Dark brown; mid-eastern skin types	Very rarely burns, tans very easily
VI	Black; African American	Never burns, tans very easily

Photography & Video Release

In order to track our progress, we at the Vein and Laser Institute likes to incorporate the use of photos. It helps us to thoroughly see the changes in your body from beginning to end. Photos are to be used for documentation/insurnace purposes, & if consented as advertisement for the product, and/or service etc.

PLEASE READ & INITIAL THE FOLLOWING:

_____ I consent to having "Before" and "After" photographs of my service/procedure.

_____ Photographs will be used for the purpose of documentation.

These photographs MAY _____ or MAY NOT _____ be used for advertising purposes (social media, publications, education, etc.)

_____ NO photographs at all

SIGN & DATE:

I understand that my consent may be revoked in writing but not by implication. By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby.

Patient Signature: _____ **Date:** _____

I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and psychological status. I, _____, represent to the physicians and staff that I am at least 18 years of age or, if not, I am accompanies by a legal guardian. I hereby consent to and authorize a history examination by my doctor or staff as may be assigned by him/her.

If appropriate, I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original.

Patient Signature: _____ **Date:** _____

The Vein and Laser Institute

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 who may be involved in treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that the Vein and Laser Institute restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that the Vein and Laser Institute is not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions.

Patient Name: _____ **Date:** _____

Patient Signature: _____

I consent to disclosure of my Personal Health Information to the following family members or friends who live at my home or place of residence:

_____

_____

Patient Signature: _____ **Date:** _____

Please read & initial the following:

_____ I authorize a representative of the Vein and Laser Institute to leave medical communication/results on my answering machine, or voicemail.

_____ I would prefer to receive medical communication/results by mail, under “Confidential” cover.

OFFICE USE ONLY		
I attempted to obtain the patient’s signature in acknowledgment on receipt of this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:		
Date:	**Initials:**	**Reason:**

Vein and Laser Institute
Cosmetic Financial Policy

We are committed to providing you with the highest quality of care regarding your cosmetic service utilizing only the best materials and education available. We have formulated a financial policy to continue to provide excellent service to you and minimize our administrative costs.

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE.

Our office accepts cash, debit and credit cards; MasterCard, Visa, Discover and American Express.

Charges may be incurred for appointments that are missed or cancelled without two full business days advanced notice.

If you have any questions regarding our financial policy, please do not hesitate to ask. Our dedicated staff is committed to providing you with the most positive experience at the Vein and Laser Institute.

I, THE PATIENT, AGREE TO PAY ANY AND ALL COLLECTION COSTS AND ATTORNEY'S FEES ASSOCIATED WITH COLLECTION OF ANY AMOUNT.

_____ _____
Printed name of patient/responsible party Date

_____ _____
Signature of patient/responsible party Date

Patient Treatment Guide Check-List

Name: _____

Circle all that you're interested in:

- Varicose Veins
- Spider Veins
- Facial Wrinkles
- Sun/Age Spots (brown/red spots)
- Acne
- Scarring
- Hair Removal
- Rosacea
- CoolSculpting (fat reduction)
- Skin Tightening & Cellulite Reduction
- Injectables & Fillers
- Other: _____