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	Porcelain	Always burns, never tans
II	Fair/Pale	Usually burns, tans with difficulty
III	Beige	Sometimes mild burn, gradually tans
IV	Olive/Light brown	Rarely burns, tans with ease
V	Brown	Very rarely burns, tans very easily
VI	Dark to deepest brown	Very rarely 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/insurance 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:** _____

Vein and Laser Institute
Privacy Disclosure Information Authorization

I, _____, have been offered or received the Privacy Notice for Vein and Laser Institute and signed the authorization for the following:

Please list below whom we can speak with and release information to:
(Medical Records release will need to be signed)

Family or Friend Name	Relationship to patient	Phone Number	Leave messages/speak with:	Review your account with:	Ok to pick up prescriptions, order, and medical records

I allow message to be left on the phone number I provided on the patient information form.

_____ YES _____ NO

Patient Portal: I consent to participate in the PATIENT PORTAL and understand that my personal health and individually identifying information is made available to me and/or my designee in the web-based portal application. I understand that I am responsible for safeguarding my access information, and should I choose to provide access to an Authorized Representative, they would have the same ability to perform all the same functions I am able to perform.

EMAIL: _____

Patient Signature: _____ Date: _____

Relationship to Patient: _____

Refusal of above: _____ Date: _____

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.

Cancellation/ No-Show Policy: if an appointment is not cancelled at least 24 hours in advance, or you "no-Show" on the day of your scheduled appointment, you will be charged a $ 50.00 fee.

Initials: _____

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