**Personal Profile and Health History**

Today’s Date: Male Female

Last Name First DOB

Street Address City, State, Zip

Home Phone Cell phone

## Communication:

* You may leave confidential clinical information on my answering machine
* You may send me email:

## Email:

* You may send me text message confirmations: **Cell Provider** (example: ATT, Verizon)

Occupation

Primary Care Physician Phone

Are you under doctors’ care at this time? Yes- For? No

Emergency Contact Phone

How did you hear about us?

List all medications including prescription and over the counter drugs, vitamins, herbs, and supplement:

Are you using any medication purchased outside the USA? ………………Yes/ No (circle answer) Are you allergic to any medications? …Yes / No

List all medication allergies:

Are you allergic to latex, Lidocaine, or any lotions? ………………Yes / No Do you have any active skin diseases or infection? ………………Yes / No

Have you had any previous laser treatments/skin treatment? ………………Yes / No

Describe: Date

Does your skin remain discolored after healing from a cut? ………………Yes / No Do you use facial depilatories or hot wax? ……………………………………………Yes /No

Do you Sun bathe? …………………………Yes/ No **Date** of last sun exposure:………………………………………………… Are you currently using, or have you used a tanning bed or self-tanner? Yes- Date: No

What skin care products are you currently using?

Do you use morning and evening? ………………Yes / No Are you satisfied with product? …….Yes / No

Medical History: Please check all that apply:

* Cancer treatment
* Bleeding Disorders
* Hirsutism
* Polycystic ovary disease
* Botox
	+ Rosacea
	+ Coagulation problem
	+ Herpes I/II
	+ Keloids
	+ Diabetes
	+ Skin Cancer
* Tattoos
* Endocrine disorders
* Cold sores
* Metal Implants/Copper
* IUD
	+ Pacemaker
	+ Vitiligo
	+ Gold therapy
	+ Permanent makeup
	+ Other
		- HIV
		- Implants
		- Shingles
		- Lupuserythematosus
	+ Electrolysis
	+ Filler injections

**HAVE YOU EVER TAKEN ACCUTANE?** Yes When No

|  |
| --- |
| **Females** answer the following questions:Are you pregnant? Yes NoAre you breastfeeding? Yes NoAre you planning pregnancy during the course of your treatment? Yes No During pregnancy do you develop hyper pigmentation of masking? Yes NoDo you have regular periods? Yes NoAre you going through menopause? Yes NoHysterectomy? Yes NoBirth Control? Yes No |
| I confirm that the answers to the questionnaire are true and correct. |
| Signature of Client: Print Name:  |
|  Signature of Consultant:  |  |
|  Reviewed by MD/NP:  |  Date: \_\_\_ ­ |

# Photographic Release Form

Record of authorization for taking and publication of photographs in connection with the medical services, which I am receiving from my physician, Dr. Mack D. Stewart, I consent that photographs may be taken of me or parts of my body under the following conditions:

1. The photographs may be taken only with my consent of my physician and under such conditions and at such time as may be approved by him.
2. The photographs shall be taken by my physician or by a photographer approved by my physician.
3. The photographs shall be used for medical records and media purposes, and if in the judgment of Dr. Stewart, medical research, education, or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals, books, pamphlets, internet or used for any other purpose which he may deem proper in the interest of medical education, knowledge, or research: provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.

**Opt in:** I give my permission for photographs to be used for media purposes within Pure Radiance (before & after photos, research, etc.). (Initial):

**Opt out:** The photographs can only be used for medical records, not for media purposes. (Initial): \_\_

**Patient's name (print): Date:**

**Patient's signature: Phone:**

**Types of treatment**:

*If a minor patient is unstable to affix signature:*

## Proxy/Guardian's name (print): Proxy/Guardian's signature: Relationship:

**HIPAA ACCESS FORM FOR PROTECTED HEALTH INFORMATION**

I understand that it is a policy of Pure Radiance Laser Retreat to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services, I would like for the following person/people to have access to my Private Health Information:

|  |  |  |
| --- | --- | --- |
| **Name(s) (Please Print)** | **DOB** | **Information Access Preferences** |
| 1. Myself (patient of legal guardian) | N/A |  |
| **Clinical Information** |
| 2. |  | □All OR □Restricted\* |
| 3. |  | □All OR □Restricted\* |
| 4. |  | □All OR □Restricted\* |

\*Clinical Info Restricted—If you checked this box above, please specify what clinical information you DO NOT wish to share with the person(s) in the above boxes:

* Botox □ Laser Hair Removal □ DOT Laser
* Fillers □ Coolsculpting □ Hormone Replacement Therapy
* Other

## Communication:

* You may leave confidential clinical information on my answering machine
* You may send me email: **Email:**
* You may send me text message confirmations: **Cell Provider** (example: ATT, Verizon)

 /

## Patient Signature Date Witness Signature

**Patient Consent for Use of Email Communications Letter**

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at info@pureradiancemedspa.com. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is the close of each business day (closed on Sunday). If the email is received after the office has already closed, it will be responded to by the end of the next day. The service provider may delay message delivery. Should you require urgent or immediate attention, this medium is not appropriate.

When sending emails, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name and return telephone number in the body of the message.

*Communications relating to diagnosis and treatment will be filed in your medical record.*

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

I understand that this office will not be responsible for information loss or delay, or breaches in confidentiality that are due to technical factors beyond Pure Radiance’s control.

I understand and agree to the above email policy, by signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

Patient Signature Date

# No Show/Cancellation Policy

Here at Pure Radiance we strive to be on the cutting edge of technology and treatment to satisfy your needs. It is very important that we provide the best type of care possible for those that seek our services.

In the event that you miss a scheduled appointment, or do not cancel your appointment 24 hours prior, any deposit will be forfeited as a “No Show Fee”. A “No Show” prevents us from treating other patients during that time due to the fact that we do not double book procedures. If you cancel your appointment less than 24 hours before, we will require a deposit fee in order to schedule any future appointments.

If you arrive more than 10 minutes late for your scheduled appointment, without prior notice, it will be considered a “No Show.” At that time, your deposit will be forfeited as “No Show Fee”.

We request that you give us ample notice if you need to cancel or to reschedule your appointment. It is our mission to provide the best possible care and consideration to all patients by scheduling the room for your consultation/treatment as well as providing the service provider for your service(s).

## I agree and understand Pure Radiance Laser Retreat’s No Show Policy

Print Name: Client Signature: Date:

Witness: Date: