Skin Rejuvenation Clinic

Client Intake Questionnaire

Personal Information

Last Name_____ **First**_____ **MI**_____ **DOB**_____/_____/_____ **Age**_____ ☐ M ☐ F
Address_____
City_____ State_____ Zip_____
Home Tel _____ Work Tel_____ Cell_____
I would like to receive appt. communications via: ☐ Email ☐ Text ☐ Phone ☐ I do **NOT** wish to receive appointment communications
I give my consent for the clinic to leave a message via (check all that apply): ☐Email ☐Text ☐Phone ☐Do not leave any messages
Email address_____
☐ It is **not** ok to send a monthly e-newsletter with sales/specials via email. (*We do not sell, share or spam any information you provide. Our email correspondence is kept to a minimum*.)

Marital Status: ____Single ____Married ____Divorced ____Widowed ____Separated # of Children:_____

Work Status: ____Full-Time ____Part-Time ____Self-Employed ____Homemaker _____Retired _____Unemployed _____Student

Occupation: _____

Emergency Contact_____ **Contact Phone**_____

From whom or how did you first hear about Skin Rejuvenation Clinic? ("X" box and fill in field if known)

	Radio ad – name of station:		Internet – name of website:
	Magazine – name of magazine:		Skin Rejuvenation Clinic website
	Newspaper – name of newspaper:		Friend or family member – name
	TV- name of station or show:		Business/Organization—name of business/org:
	Walk-in/Drive By		Other – please specify:

Skin Care Information

What is the main reason you came in for today's consultation or initial visit?_____
What conditions would you like to improve? ("x" all that apply)

	Aging		***Pigment***		***Skin Care/General***		***Other***
	Smokers lines, vertical lines above lip		Rosacea, redness		Acne scarring		Unwanted fat – area:
	Nose –to-mouth lines		Freckles		Oiliness		Thin or uneven lips
	Fine lines and wrinkles		Broken capillaries		Dryness and/or flakiness		Loose, sagging skin- area:
	Corner-of-mouth lines		Age, sun or brown spots		Pore size		Unwanted hair- area:
	Sunken cheeks		Dark circles under eyes		Acne		Nose shape or bump
	Crow's feet		Scar(s)		Facial "fuzz" or facial hair		Elimination of large pimple/zit
	Frown lines (b/t brows)		Unwanted mole(s)		Skin texture (crepiness)		Excessive sweating (underarms, hands)
	Aging hands		No lip pigment		Uneven skin tone		Uneven or sparse brows
	Mouth-to-chin lines		Melasma (Pregnancy mask)		Dull skin tone		Short and/or sparse eyelashes
	Forehead lines		Spider veins-- location:		Other—please specify:		Other – please specify:

Have you been diagnosed with any skin conditions? No Yes If yes, please specify_____

What skin care products do you frequently use?

AM

_____
_____
_____

PM

_____
_____
_____

Are you able to change your skin care regimen? No Yes

Are you taking any vitamins? No Yes -- If yes, please list_____
_____

Do you use any of the following products?

	Retin A or Retinol		Glycolic acid
	Hydroquinone		Salicylic acid
	Accutane		Other, please specify:

If you have had any reactions to any of the above products, please explain:_____
_____

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

	Body contouring procedure		Chemical peel		Fillers (Restylane, collagen, Juvederm…)
	Laser vein treatment		Botox		Laser Peel
	BBL/IPL		Microdermabrasion		Laser Hair Removal
	Acne treatment, please specify:		Plastic surgery, please specify:		Other:

Medical Information

Are you seeing any doctor, for any reason? No Yes --If yes, reason:_____

Do you have, or have you had any of the following conditions? ("x" all that apply)

	Acne		Warts		Diabetes
	Skin cancer		Multiple Sclerosis		Migraines
	Keloid scarring		Epilepsy		Autoimmune system disorder
	Dermatitis		High or low blood pressure		Staph infection
	Acne scarring		Chest pain		Easy bruisability
	Cold sores		Heart attack		Depression
	Cancer— list type:		Shortness of breath		Stomach problems
	Eczema		Hepatitis		Allergies to strawberries
	Active rosacea		Asthma		Other:
	Undiagnosed lesions		Thyroid Disorder		Other:

Please list all medications and vitamins you take:_____
_____
_____

Please list any allergies you may have, including allergies to medications and soy:_____
_____

Please list all surgeries and approximate dates, including cosmetic:_____
_____

Are you pregnant or planning to be? No Yes Do you ever tan in tanning beds? No Yes

Do you smoke? No Yes Are you able to wear sun protection everyday? No Yes

Comments or questions:
_____
_____
_____

I, _____ do fully understand all of the questions above and have answered them all correctly and honestly. By signing below I release Skin Rejuvenation Clinic, P.A. and its employees from all liability.

Signed by client _____ Date_____

Signed by skin care professional_____ Date_____

HIPAA Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

According to the Federal Law called HIPAA (Healthcare Information Portability and Accountability Act), disclosures of information about you for some purposes do not need special consent. These disclosures are for the purpose of providing your medical care or for billing your insurer. For example, a doctor may call another doctor about your medical problems and discuss your condition without special consent. We may contact your insurer about a claim for your care without special consent. We may arrange for your care by a pharmacy without special consent. We may discuss arrangements for your care at a hospital without special consent.

There are some disclosures of your private information that are required by law, such as reporting certain diseases to public health agencies, reporting victims of abuse, and disclosures for organ donation.

In addition, we may disclose private health information to your family members relevant to their involvement in your care or relevant to reimbursement issues.

In general, other disclosures of private health information will be made only with your consent in writing, and you have the right to revoke that consent.

You have certain rights to protect the confidentiality of your health information:
You can request to have restrictions on the use or disclosure of information about you for treatment,
payment, or health care operations purposes. However, we are not required to agree with these restrictions, and we may decide not to accept the responsibility for your care under these circumstances. In an emergency, you will always receive care before adjudicating these issues.

You have the right to request and we have the right to accommodate reasonable requests for you to receive confidential information by alternative means or at alternative locations. For example, you might wish to receive letters from us at an address not your usual residence, and we would try to accommodate you.
You have the right to inspect and receive a copy (for a fee) of your health information in this office. Skin Rejuvenation Clinic, PA may deny access to records if there were a question of endangerment to you or to others by that access. You have the right to request an amendment of your confidential information, but we have the right to deny that request in certain circumstances. You cannot amend a record that we did not create at Skin Rejuvenation Clinic, PA. You have a right to receive an accounting of disclosures of your confidential information, but such a listing does not have to be made in circumstances:

- Pertaining to your treatment, payment issues, or health care operations.
- When the disclosure is to you of your own information.
- When the disclosure is to persons involved in your health care.
- For national security or intelligence purposes or for certain law enforcement purposes.

In general, if there is a request for use of your health information, and there is any question about the impact of HIPAA on that request, you will be asked for written consent for release of that information first. We proactively intend to follow the letter and spirit of the confidentiality law.

If you have a complaint about privacy of your medical records, or you believe that your privacy rights have been violated you may: Complain to this practice in writing, email to email@skinrejuvenationclinic.net. Complain in writing to the Secretary of Health and Human Services, 200 Independence Ave, Washington DC 20201. A detailed version of this notice is available upon request.

I have reviewed and understand the above:

_____ _____

Signature Date