Forest Medical Spa
CLIENT INFORMATION

Client: _____
Last Name First Name Middle Initial

"Preferred Name": _____

Address: _____ City_____

State_____ Zip_____

Home Phone: _____ Cell: _____

Business Phone: _____ Email address: _____

Sex: __M __F Age: ____ Date of Birth: _____

Social Security#:_____ _____

Marital Status: __Married __Single __Divorced __ Widowed

EMPLOYER: _____

Occupation: _____

Whom may we thank for referring you?
_____

Is that person your _____ Doctor ___Family ___Other?

Confidential Medical Information

Allergies or sensitivity to medications (including local anesthetics, latex, aspirin):
_____

Have you ever used any products that caused a bad skin reaction?
_____

Are you allergic or sensitive to any or all of the following: ___milk ____apples ____citrus ____grapes ____aloe vera ____hydroquinone ____perfumes?

Are you currently taking any form of blood thinner (aspirin, ibuprofen, etc):_____?

Name: _____

Are you currently taking/using Accutane®, Tazorac, Avage, Retin-A, Differin, Triluma? _____

Are you currently using Biore®/snore strips, wax, or depilatories?
_____

Do you wear contact lenses? _____ Do you have permanent make-up?_____

When were you last exposed to the sun (including tanning beds)?
_____

Do you use self-tanning lotions?
_____

Do you smoke? _____
Do you develop cold sores/fever blisters? _____

Have you had any type of medical, aesthetic, or surgical procedures within the last year? If so, which?_____

Do you have regular collagen, Restylane® or Botox® injections?_____

Do you consider your skin: SENSITIVE_____ RESILIENT_____NOT SURE_____?

What is your daily home care skin care regimen?
_____

What are the cosmetic improvements you would like to see in your skin?
_____

(WOMEN ONLY: Are you pregnant, lactating or trying to become pregnant? _____)

PATIENT INFORMATION CONSENT FORM

I have read and understand **Forest Medical Spa's** Notice of Information Practices. I understand that **Forest Medical Spa** will use and/or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment, payment. I understand that I have the right to restrict how my PHI is used for treatment, payment, or administrative operations if I notify the practice of my wishes. I understand that **Forest Medical Spa** will consider requests for restriction on a case-by-case basis, but is not legally bound to agree to requests for restrictions.

I understand that **Forest Medical Spa** does not allow the use of PHI for the purposes for marketing, fund raising, solicitation, or for research studies.

I hereby consent to the use and disclosure of my personal health information for the provision of treatment, facilitation of payment, evaluation of service quality, or administrative operations.

Designated Individuals Authorization

I hereby authorize the persons listed below to request and receive any personal health information regarding my treatment, payment, or administrative operations related to treatment or payment. I understand that the identity or designated parties must be verified prior to the release of any information.

Name_____ Relationship_____
Name_____ Relationship_____
Name_____ Relationship_____
Name_____ Relationship_____

Communication from Forest Medical Spa

Messages from **Forest Medical Spa** may be left for me at the following location(s):

____ Home ____Work ____Cell

- I have been informed that a copy of Forest Dermatology's (Forest Medical Spa's) "Notice of Privacy Practices" is available at my request.
- I authorize release of medical information to authorized parties.

Patient Name

_____
Signature

_____
Date