



Skin & Laser Medical Center

DR. DYAN HARVEY-DENT
Phone(813)684-9600 Fax(813)662-9777

4325 Lynx Paw Trail
Valrico, FL 33596

Cosmetic Medical History

Please complete the following: Date: _____ SS#: _____ DOB: _____

Name: _____ Email: _____

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

Home Telephone: (____) _____ Cell: (____) _____

Employer: _____ Work Number: (____) _____

Whom may we thank for referring you? _____

What is the reason for today's visit? _____

Yes No

Are you allergic to any medications, such as penicillin, aspirin, etc? If yes, please provide names of medication. _____

Do you bleed excessively after a cut, wound, or surgery?

Are you subject to fainting, dizziness, nervous disorders?

Are you pregnant or breast-feeding?

Do you take medications? If yes, list medications. _____

Are you an insulin dependent diabetic?

Do you have a history of stroke?

Do you have a history of a recent cancer?

Do you have a history of blood clots?

Do you have a history of cold sores/fever blisters?

Do you have any active skin or general disease?

Have you had any recent waxing or used depilatories

Microdermabrasion

Chemical peels

Laser resurfacing

Botox

Injectable fillers (Juvederm, Restylane, Radiesse, etc.)

Do you have permanent makeup/tattoos? If so, where? _____

Do you use Retin-A, Glycolic acid, Hydroquinone (skin bleaching agent) products?
If yes, please specify. _____

Have you been on accutane in last 6 months?

My skin is: oily dry combination

What type of skin care products do you use? _____

I have informed Dr. Harvey-Dent, that I am in good health and not under the care of a physician.

Initial _____ or I am under the care of a physician. Initial _____

Signature

Date

COSMETIC INTEREST QUESTIONNAIRE

Treatments of interest to you (please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Cellulite treatment | <input type="checkbox"/> Laser hair removal |
| <input type="checkbox"/> Oxygen facials | <u>Wrinkle Fillers</u> |
| <input type="checkbox"/> Liver spots/age spots | <input type="checkbox"/> Juvederm |
| <input type="checkbox"/> Skin care advice/products | <input type="checkbox"/> Collagen therapy |
| <input type="checkbox"/> Skin rejuvenation | <input type="checkbox"/> Radiesse (Semi-permanent Filler) |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Silikon 1000 (Permanent Lip Filler) |
| <input type="checkbox"/> Acne Program | <input type="checkbox"/> Botox cosmetic |
| <input type="checkbox"/> Chemical peels | (Botulinum Toxin Type A) |
| <input type="checkbox"/> Mesotherapy (Cellulite/Fat Melting) | <input type="checkbox"/> Lip Implants |
| <input type="checkbox"/> Facial vein treatment | |

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age:

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles:

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

HIPAA PRIVACY CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has the right to request and review our Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

This Consent was signed by:

Signature - Patient, Parent/Guardian/Personal Representative

Date

Print Name - Patient, Parent/Guardian/Personal Representative

Relationship to Patient



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****APPOINTMENT POLICY****

TO AVOID EXCESSIVE WAIT TIME FOR YOU AND OTHER PATIENTS SCHEDULED, WE ASK THAT YOU PLEASE ARRIVE ON TIME. PLEASE BE ADVISED THAT WE RESERVE THE RIGHT TO RESCHEDULE AN APPOINTMENT IF A PATIENT IS MORE THAN 15 MINUTES LATE.

****CANCELLATION POLICY****

IN AN EFFORT TO MAINTAIN PATIENT SATISFACTION AND EFFICIENT PATIENT SCHEDULING, THIS OFFICE HAS A CANCELLATION POLICY THAT REQUIRES ATLEAST 24 HOURS NOTIFICATION OF A SCHEDULED APPOINTMENT. IF A PATIENT FAILS TO KEEP HIS/HER APPOINTMENT, HE/SHE WILL BE CHARGED \$35. THIS COST WILL BE THE RESPONSIBILITY OF THE PATIENT AND IS NOT COVERED BY INSURANCE.

PLEASE NOTE: WE REQUIRE ATLEAST 48 HOURS NOTIFICATION OF CANCELLATION FOR SATURDAY APPOINTMENTS OR APPOINTMENTS WITH MORE THAN AN HOUR TIME SLOT. IF A PATIENT FAILS TO KEEP HIS/HER APPOINTMENT, HE/SHE WILL BE CHARGED \$50.

I CERTIFY THAT I HAVE READ THE FINANCIAL AND CANCELLATION POLICIES OF SKIN AND LASER MEDICAL CENTER AND AGREE TO ABIDE BY THEM.

Signature: _____ Date: _____

****CONSENT FOR PHOTOGRAPHY****

I, THE UNDERSIGNED, DO HEREBY AGREE TO THE FOLLOWING. I AM ALLOWING DR. HARVEY-DENT, OR A STAFF MEMBER, TO TAKE PHOTOS OF MY TREATMENT AND/OR TREATED AREAS TO BE USED FOR THE PURPOSE OF MONITORING MY PROGRESS AND/OR EDUCATION.

AT MY REQUEST MY IDENTITY WILL REMAIN ANONYMOUS. _____ (PLEASE INITIAL)

***MAY WE USE YOUR PHOTOS FOR OUR BEFORE AND AFTER BOOK FOR IN OFFICE USE ONLY?**

Print Patient Name

Patient Signature

Witness

Date

MAY WE CALL AND/OR LEAVE A MESSAGE TO REMIND YOU OF YOUR APPOINTMENT? YES____ NO____