SKINMD, PLLC NEW PATIENT INFORMATION

Name: _____ Birth Date: _____/_____/_____ Age: _____
Address: _____ Sex/Gender: M F Intersex Transgender
City: _____ State: _____ ZIP Code: _____
Home: ( )_____ Work: ( )_____ Cell: ( ) _____
Email: _____ Preferred Gender Pronoun: _____
Allergies: _____ Profession _____
How did you hear about SkinMD? _____
Emergency Contact: _____Telephone: _____
Relationship to Patient: _____

Please put a check mark next to a past or current medical condition:

* *may alter wound healing*

___*Lupus or other autoimmune deficiency
___Thyroid dysfunction (Hyper or *Hypo thyroid)
___*Bleeding disorder/ Bruise easily
___Treatment with Accutane ® in the last year
___Treatment with Minocin/Tetracycline ® in the last month
___Keloid or very thick scarring
___Psoriasis or Vitiligo
___Pulmonary embolism/blood clot
___Leg ulcer or Phlebitis
___Alopecia/ Hair Loss
___*Coumadin or anti-clotting/blood thinning Rx
___Cystic Acne
___Cancer; if yes, what type? _____
___Herpes simplex or fever blisters
___*Diabetes
___Epilepsy/ Seizure Disorder
___Scars that turn white or brown
___Dark spots after pregnancy, skin injury
___HIV/ AIDS
___Hepatitis
___Polycystic Ovary Syndrome (PCOS)
___Hirsuitism
___Transplant Anti-Rejection Drugs
___Rheumatoid Arthritis "Gold" Therapy
___Eczema/Skin Diseases
___Other:_____

If history of Herpes/Fever Blister/Shingles Date of Last Outbreak _____(*With + Hx. of herpes – Start pt. on Valtrex 500mg. BID 2 days pre & 3 days post tx.)*

Rx Written/Called in to _____ Date _____ Pharmacy # _____

Please list ALL <u>medications or herbal supplements</u> that you are currently taking:

_____

_____

_____

Have you undergone any surgery recently (past 5 years)? Y N: _____

Do you have pacemaker/ metal stent/ metal implants in your face or body? Y N: _____

Do you exercise regularly? Y N: _____

What is your average night's sleep? _____

Do you smoke? Y N If yes, # packs/day: _____ How long have you smoked? _____

Are you pregnant or trying to become pregnant? Y N **Are you currently breast-feeding?** Y N
Are you on Birth Control Pills / Patch / HRT? Y N **Perimenopausal/Menopausal/Postmenopausal** Y N

_____ _____
Patient Signature **Date**

What is your daily consumption of:

Water _____oz. Coffee_____oz. Tea_____oz. Soda/Pop_____oz. Alcohol_____oz. Red Bull_____oz.

What water temperature do you cleanse with? _____Cold _____Warm _____Hot

Any special skin concerns?

___Oily	___Dry	___Sensitive
___Flaking	___Breakouts/Acne	___Scarring
___Dry Patches	___Uneven Pigmentation	___Redness
___Pores	___Melasma	___Texture
___Wrinkles	___Facial Veins	___Sun Damage
___Moles	___Spider Veins/Leg Veins	___Unwanted Hair
___Dark Circles	___Rosacea	___Crepiness/ Laxity

What is your current skin care routine?

___Soap	___Cleanser	___Toner
___Scrub	___Masque	___Moisturizer
___Sunscreen	___Serum	___Other: _____

What brand(s) of skincare do you use: _____

What facial/skin treatments have you had?

__Filler (Radiesse/Juvederm/Belotero/ Bellafill etc.) ___Botulinum Toxin (Botox/Dysport/Xeomin/Jeuveau)

__ Laser Hair Removal __ Laser Vein Removal __ Chemical Peels

__ IPL/PhotoFacial __ Spa Facials __ Microneedling/DermaPen

__ Microdermabrasion __ C02/Laser Resurfacing __ Thermage/Laser Tightening

__ Fraxel/Nonablative Laser __ Face Lift /Mini Lift/Neck Lift __ Blepharoplasty (Eyelid Surgery)

__ Rhinoplasty (Nose Surgery) __ Other:_____

Please list 3-6 main concerns you would like to address during your consultation today: (you may list fewer)

_____

_____

_____

How much downtime and/or time off work or social events can you devote to any medical skincare treatments?

___1-3 Days ___4-6 Days ___7-9 Days ___9+ Days ___No downtime preferred

How much do you want to spend on your skin health and rejuvenation needs?

___$0-$500 ___$501-$1,000 ___$1,001-$2,500 ___$2,501-$5,000 ___$5,001-$7,500 ___$7,501 +

We accept CareCredit Healthcare card for your cosmetic procedures. Applying is fast, easy, secure and can be accessed from the office. Would you like to apply for CareCredit today?

___Yes ___No

_____ _____

Patient Signature **Date:**

SKINMD, PLLC SKIN TYPING

Please answer the following questions by circling the number which best describes you. Your clinician will total the score during the consultation.

My ethnic origin is closest to: (Check one)	I. Very fair (Celtic and Scandinavian)	☐
	II. Fair-skinned Caucasians with light hair and light eyes	☐
	III. Pale-skinned Caucasians with dark hair and dark eyes	☐
	IV. Olive-skinned (Mediterranean, some Asian, some Hispanic	☐
	V. Dark-skinned (Middle Eastern, Hispanic, Asians, some Africans)	☐
	VI. Very dark-skinned (African)	☐
My eye color is:	Light blue	0
	Blue/green	1
	Green/gray/golden	2
	Hazel/light brown	3
	Brown	4
My natural hair color at age 18 was:	Red	0
	Blonde	1
	Light brown	2
	Dark brown	3
	Black	4
The color of my skin that is not normally exposed to sun is:	Pink to reddish	0
	Very pale	1
	Pale with a beige tint	2
	Light brown	3
	Medium to dark brown	4
	Dark brown – black	6
If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:	Burn, blister and peel	0
	Burn, then when the burn resolves there is little or no color change	1
	Burn, but then turns to tan in a few days	2
	Get pink, but then turns to tan quickly	3
	Just tan	4
	Just gets darker	5
	My skin color is so dark I can't tell	6
When was the last time the area to be treated was exposed to a significant amount of sunlight, a tanning bed, or tanning lotions?	Longer than one month ago	0
	Within the past month	1
	Within the past two weeks	3
	Within the past week	4
	Total Score	☐

Circle All Nationalities Associated with your Genetic Makeup:

Native American White Asian Hispanic Mediterranean Middle Eastern Afro-American Indian Irish English Greek German Italian Spanish/Portuguese

If your score is:	Your skin type is	Notes:
0 – 3	I	
4 – 7	II	
8 – 11	III	
12 – 15	IV	
16 – 19	V	
20 - 24	VI	

Authorization to Leave Personal Health Information by Alternate Means

Patient Name_____ Date of Birth_____

(Please check all that apply)

__May leave detailed message on home voice mail #_____
__May leave detailed message on work voice mail #_____
__May leave detailed message on cell voicemail #_____
__May leave detailed message with spouse/partner (name & phone#)_____
__May leave message with other family member (name & phone#)_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that the doctor and hospital will use and disclose my personal health information to provide treatment, to receive treatment, to receive payment for care provided, and for other health care operations.

I have been informed of my medical providers Notice of Privacy Practices containing a more complete description of the uses and disclosure of my protected health information. I have been given the right to review and receive a copy of such Notice to Privacy Practices. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient Signature **Date:**

SkinMD
Keeping you youthful for years to come

SkinMD Cancellation Policy

In order to provide our patients with timely and effective service, we must require our patients to adhere to our cancellation policy.

Our cancellation policy is as follows:

- We require credit card information on file to hold & confirm appointments.
- We require 24- hour notice for any appointments needing cancellation or rescheduling.
- Patients who cancel or need to reschedule appointments without giving 24-hour notice; or patients who do not arrive at scheduled appointments ("no-shows") will have a **$150 charge billed to the credit card we have on file for them.**
- ***If possible***, we will accommodate late patients. If you will be 15 or more minutes late for an appointment, we require a phone call to determine whether we will be able to accommodate you or if you will need to reschedule. If we are unable to accommodate you, we will re-schedule you for the next available appointment and your credit card will be billed.

Thank you in advance for your consideration!

_____ _____

Patient Signature **Date:**

SkinMD

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