PRIMARY AESTHETIC

Skin Care

Imagine a more youthful you!

----------NEW PATIENT INTAKE INFORMATION----------

Name (First, Last) _____, _____ Date _____

Preferred Name: _____

Address:_____ Apartment #_____

City:_____ State:_____ Zip:_____

Marital Status (Circle): Single Married Widowed Divorced Sex at Birth (Circle): Male Female

Birth Date:_____ Age: _____ Gender (Circle): Male Female

Home Phone:(_____)_____ Cell Phone:(_____)_____

Email Address:_____ How did you hear about us?(Name)_____

Best method of contact to leave any confidential information regarding your treatment (please circle): Home Work Cell Email

What would you like to discuss with the NP Ginsberg today:

_____

_____

Primary Care Physician Name:_____ Phone Number:(_____)_____

Your Employer:_____ Occupation:_____

Emergency Contact Name:_____ Number:_____ Relationship:_____

Pharmacy Name:_____ Number:_____

List all Surgeries (Hospitalization and the Date of Occurrence) and Current Illnesses or any Recent Accidents:

List the name of all <u>medications</u> you are presently taking or have taken within the last month. Please inclue the name of the drug, dosage and frequency:

Do you have or have you had any of the following: (circle for each, provide date occurred if Yes)

Aids / HIV	No	Yes	Facial Implants	No	Yes	Pneumonia	No	Yes
Arthritis/	No	Yes	Fever Blisters	No	Yes	Rash/Allergic Skin Reaction	No	Yes
Asthma	No	Yes	Goiter / Thyroid	No	Yes	Sinus Problems / Infections	No	Yes
Autoimmune Disorder	No	Yes	Hay Fever / Allergies	No	Yes	Stroke	No	Yes
Bronchitis	No	Yes	Headaches / Migraine	No	Yes	Tonsillitis	No	Yes
Cancer	No	Yes	Heart Trouble	No	Yes	Tuberculosis	No	Yes
Depression	No	Yes	Hepatitis	No	Yes	Ulcers	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes	Hernia	No	Yes
Dizziness / Vertigo	No	Yes	Keloid Scaring	No	Yes	Are you Pregnant?	No	Yes
Ear Infection	No	Yes	Kidney Problems	No	Yes	Date of your last period: _____		
Epilepsy / Seizures	No	Yes	Lupus	No	Yes	**Have you ever been treated with GOLD?_____**		

DO YOU SMOKE? NO YES DO YOU DRINK ALCOHOL? NO YES DO YOU USE RECREATIONAL DRUGS? NO YES

List ALL drug, food allergies, and/or latex allergies: **Do you wake up in the morning with puffy eyes?**

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PATIENT CONSENT FOR USE AND DISCLOSURE OF (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with ***Primary Aesthetic Skin Care,*** **"**Notice of Privacy Practices", and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

----------FINANCIAL RESPONSIBILITY POLICY----------

I understand that payment is required for all services rendered. I understand that Primary Aesthetic Skin Care accepts payment in the form of cash, from approved finance companies or credit card. In the event that my account must be turned over to collections, I understand that a **$100.00** collection fee will be added to my account balance. Primary Aesthetic Skin Care does not accept or file any insurance. My printed name and signature below signifies my understanding and willingness to comply with this policy.

----------MISSED / LATE APPOINTMENT POLICY----------

We have a limited number of appointments per day, thus there is often a waiting list. We will only give you the quality care you deserve. We want all of our patients to have enough time for a comprehensive appointment. In fairness to others, if you schedule an appointment, it is essential that you keep it. If you must cancel or reschedule an appointment, **NOTIFY US AT LEAST 24 HOURS IN ADVANCE**.

If you are going to be more than 10 minutes late, please notify us. If you are more than 15 minutes late, your appointment **will be rescheduled**. We want to insure that we have the proper amount of time to provide the quality of care you deserve.

I understand that if I frequently miss appointments or am frequently late for appointments then a credit card may be required to book future appointments. I also understand that a deposit of **$50.00** will be required to book appointments for cosmetic services.

---------- CONSENT FOR PHOTOGRAPHY / VIDEO----------

When treated at Primary Aesthetic Skin Care, you will be asked to sign the following Consent form: You can consent or decline consent at that time.

I hereby consent to cosmetic and dermatology images and / or video being made of me or my child / dependent. These photos will be used as before and after documentation in the office. I agree that duplicates may be made for the referring doctor.

I agree that the images and results may be used for the following purposes:

- Electronically emailed to my treating health
- Used by NP Ginsberg for education and training purposes
- Used in paper or electronic health publications
- Used by NP Ginsberg for Advertising purposes
  (Marketing, Newspapers, TV, Magazines, Social Media etc.)
- Television, Facebook, Social Media and other media
- Display photos in the office
- Showing our patients

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----------CONSENT FOR ADDITIONAL TREATMENT / TOUCH-UP----------

At Primary Aesthetic Skin Care, our goal is to achieve the optimal result in the safest, fastest way with the least number of treatments necessary.

As everyone's individual body and chemistry differ, people often do respond differently to treatments. Your first session doing a new procedure may sometimes be the session where we find your ideal treatment protocol. Laser energy settings and aesthetic injectable amounts vary and we will customize what will best suit your needs. Once we know this, similar treatments will be standardized for your convenience.

NP Ginsberg does not believe in treating at extremely high energy settings with laser treatments, nor does she believe in over injecting. Her conservative approach and expertise leaves patients looking refreshed and rejuvenated without looking altered or overdone. We will strive to minimize the number of treatments required, so that you save time and money. Our main goal is to safely achieve your optimal results.

Many cosmetic procedures will take more than one session to safely achieve superlative, natural looking results, while others require just one treatment. Please be advised that additional treatment variations may be necessary.

I do understand that a follow-up / touch-up appointment may be necessary, and I will be billed at normal fees.

----------CONSENT FOR EXAMINATION AND TREATMENT----------

I hereby authorize NP Ginsberg, her associate(s), and/or her staff to examine me (or the patient named on this form) and to administer any and all treatment that NP Ginsberg or her associate(s) deem necessary.

My printed name & signature below certify that I have provided complete and accurate contact & medical information and that I have read, fully understand & completely agree with the HIPAA Patient Consent, Financial Responsibility Policy, Missed / Late Appointment Policy, Consent for Photography / Video, and Consent for Additional Treatment / Touch-up contained in this document and I agree to Examination and Treatment.

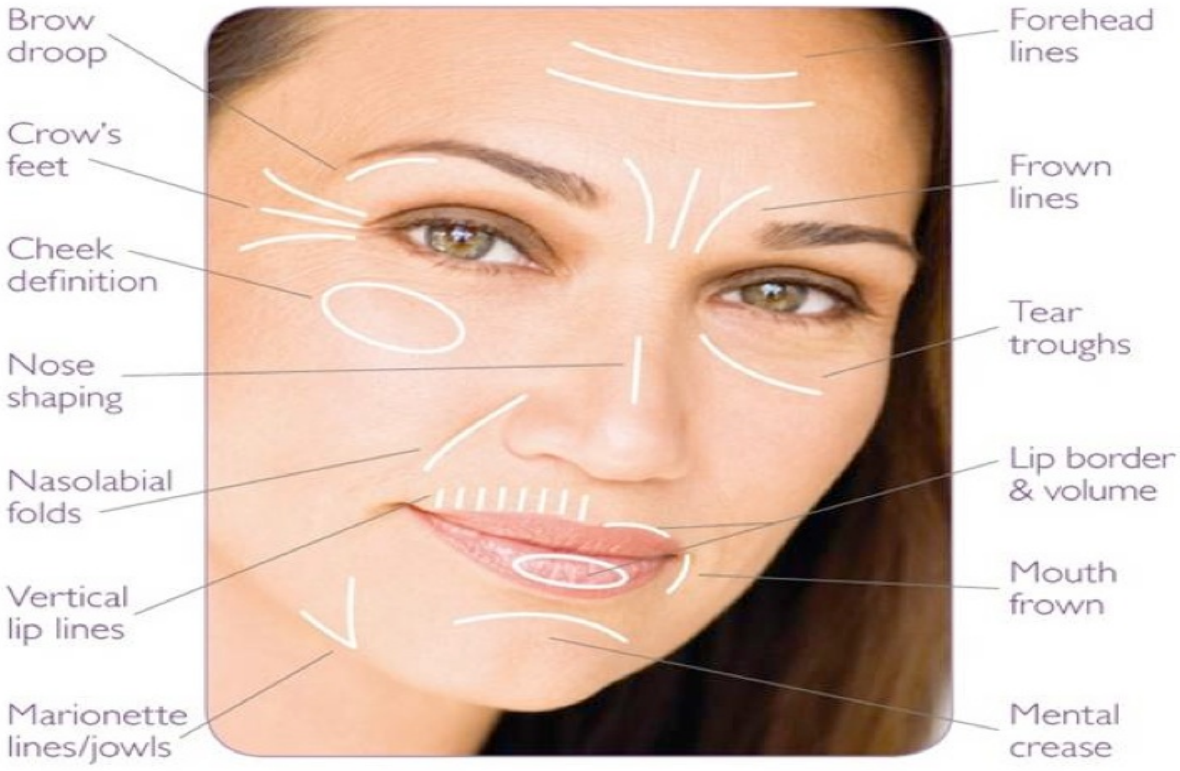
☐ _____ **Printed Name of Patient (or legal guardian)** ☐ _____ **Signature of Patient (or legal guardian)**	☐ _____ **Date**

Brilliant DISTINCTIONS® PROGRAM

ASPIRE GALDERMA REWARDS

Are you a member of Allergan's Brilliant Distinctions Program or Gladerma's Aspire Program? If not, please ask the front desk how to sign up. If you are a member, please advise the front desk you are a member so we will be sure to award you points or redeem your coupons.

PLEASE TELL US ABOUT YOUR FACE



With respect to facial aesthetics, please highlight those areas of your face that bothers or concerns you. Please circle the areas that concern you and rate from 1-5.

1 = least concerned **5 = most concerned**

Additional information or concerns you would like to discuss:

_____

_____

_____

_____

_____

Approval to send information via email or mail to:

Email address: _____

Signature _____

AESTHETIC INTEREST QUESTIONNAIRE

Please complete this questionnaire to help us better understand your aesthetic needs and concerns. During your consultation, your response will help us identify ideal treatment options.

NAME:	DATE

What is the main reason you are here for this consultation?

What aesthetic treatments and procedures, if any, have you had in the past?

If you have previously had any aesthetic treatments or procedures, were you pleased with the outcome? If no, in what way(s) were you dissatisfied?	◯ Yes	◯ No
Do you feel like you look older than you really are?	◯ Yes	◯ No
Do you have any concerns about wrinkles or fine lines?	◯ Yes	◯ No
Are you happy with the size, shape and volume of your lips?	◯ Yes	◯ No
Do you have any concerns about sun damage or age spots?	◯ Yes	◯ No
Do you have any concerns about the appearance of your skin?	◯ Yes	◯ No
Do you want to learn more about at-home skin care?	◯ Yes	◯ No

Aesthetic Products, Treatments and Procedures

Check all that you are interested in:

◯ Botox/Dysport/Xeomin	◯ Skin Tightening Procedures
◯ Dermal Filler/Wrinkle filler	◯ Fat Reduction Procedures
◯ Professional Skin Care Products	◯Aesthetician Services
◯ Lip Treatments	◯ Laser Treatments
◯ O-Shot	◯ P-Shot
◯ Laser Hair Removal	◯ Skin Rejuvenation
◯ Vaginal Rejuvenation	◯ Penile Rejuvenation