



New Patient Information

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____ Age: _____ Marital Status: _____ Gender: Male Female

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Number: _____ Home Number: _____

Email: _____

Primary Care Physician:

Office Name: _____ Provider: _____ Phone: _____

Emergency Contact:

Name: _____ Relationship: _____

Cell Number: _____ Work/Home Number: _____

Preferred Method of Contact:

With my permission, this establishment and all subsidiaries*, may contact me and leave voice mail messages in reference to any subject that assists in carrying out patient relations, such as, but not limited to: appointment reminders and laboratory results.

My preferred method of contact: Cell Phone Home Phone Work Phone Email

Patient or Legal Guardian's Signature: _____ Date: _____

How did you hear about our office? (Please be specific):

What are your favorite radio stations? _____

What magazines do you read? _____

What news publications do you read? _____

What websites do you read? _____

Areas of concerns, procedures, and/or products of interest to you: (Please check all that apply)

- Botox or Dysport
- Retin-A or Retinol
- Skin Rejuvenation
- Laser Resurfacing
- Juvederm/Restylane Dermal Filler
- Microdermabrasion
- Hair Removal
- Acne
- Sun Damage/Age Spots
- Cellulite Reduction
- Spider Vein Treatment
- Skin Care Advice
- AHA, Glycolic or Chemical Peel
- Longer Eyelashes
- Removing Facial Veins
- Weight Loss
- Facial & Eye Treatments
- Skin Care Products
- Body Contouring
- Hormone Therapy
- Other: _____

Would you like to receive emails from Red Mountain Weight Loss & Red Mountain Med Spa? Yes No

New Patient Information

HEALTH INFORMATION

Have you been under the care of a physician, dermatologist or other medical professional within the past year? No Yes, please explain: _____

Have you had any recent surgeries, including plastic surgery? No Yes, please explain: _____

Do you see a dermatologist for regular skin checks? No Yes If yes, how often: _____ Last skin check: _____

Have you ever had skin cancer? No Yes, please explain: _____

Have you ever had aesthetic treatments? No Yes, when: _____

Do you have any piercings, tattoos or permanent make-up? No Yes, where: _____

Have you had any of these health conditions in the past or present?

Cancer	<input type="checkbox"/>	Headaches (Chronic)	<input type="checkbox"/>	Hormone Imbalance	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Systemic Disease	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>
Spinal Injury	<input type="checkbox"/>	Frequent Cold Sores	<input type="checkbox"/>	Keloid Scarring	<input type="checkbox"/>
Thyroid Condition	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	Skin Disease/Skin Lesions	<input type="checkbox"/>
Hysterectomy	<input type="checkbox"/>	Immune Disorders	<input type="checkbox"/>	Any Active Infection	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
Heart Problem	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	Metal Bone Pins or Plates	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Phlebitis, Blood Clots, Poor Circulation	<input type="checkbox"/>	Eczema	<input type="checkbox"/>
Blood Clotting Abnormalities	<input type="checkbox"/>	Psychological Treatment	<input type="checkbox"/>	Rosacea	<input type="checkbox"/>

If conditions, please explain: _____

Has your physician discussed concerns about raising your body temperature? No Yes, please explain: _____

Do you smoke? No Yes Do you follow a regular exercise program? No Yes

Current Medications: _____

Current OTC Medications (including vitamins, supplements, aspirin, etc.)? _____

Medication Allergies: _____

Allergies: _____

Do you use Retin-A, Renova, Deferin, Glycolic Acid, AHA, Salicylic Acid, Topical Antibiotics, or Retinol/Vitamin A derivative products. If yes, describe which and the frequency of use: No Yes

Have you used any acne medication? No Yes

If yes, which? _____

Do you form thick or raised scars from cuts or bruises? No Yes

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HEALTH INFORMATION

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? No Yes

If yes, describe:

List your approximate daily consumption of: Water: _____ Caffeine: _____ Alcohol: _____

Do you wear contact lenses? No Yes

Do you have any metal implants or wear a pacemaker? No Yes

Have you ever experienced claustrophobia? No Yes

Have you ever ever had an adverse reaction after using a skin care product? (Please mark all that apply):

Rash Irritation Peeling Sun Sensitivity Breakout Other: _____

Have you ever had an allergic reaction to any of the following? (Please mark all that apply and explain):

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs
 Fragrance Shellfish Latex Drugs Other: _____

Please explain:

FEMALE PATIENTS - ONLY

Do you have regular menstrual cycles? No Yes If no, please explain: _____

Are you taking oral contraceptives? No Yes If yes, which?: _____

Any recent changes to or from your contraceptive method? No Yes If so, what & when? _____

Are you pregnant? No Yes

Are you trying to become pregnant? No Yes

Are you lactating? No Yes

Have you had birth via c-section within the last year? No Yes

Are you experiencing any menopause problems? No Yes

New Patient Information

AESTHETIC SKIN TYPE ASSESSMENT

GENETIC DISPOSTION	0	1	2	3	4
What color are your eyes?	<input type="checkbox"/> Light Blue, Gray or Green	<input type="checkbox"/> Blue, Green or Gray	<input type="checkbox"/> Blue	<input type="checkbox"/> Dark Brown	<input type="checkbox"/> Brownish Black
What is the natural color of your hair?	<input type="checkbox"/> Sandy Red	<input type="checkbox"/> Blonde	<input type="checkbox"/> Chestnut or Dark Blond	<input type="checkbox"/> Dark Brown	<input type="checkbox"/> Black
What is the color of your skin in unexposed areas?	<input type="checkbox"/> Reddish	<input type="checkbox"/> Very Pale	<input type="checkbox"/> Pale with Beige Tint	<input type="checkbox"/> Light Brown	<input type="checkbox"/> Dark Brown
Do you have freckles on unexposed area?	<input type="checkbox"/> Many	<input type="checkbox"/> Several	<input type="checkbox"/> Few	<input type="checkbox"/> Incidental	<input type="checkbox"/> None
Total Score for Genetic Disposition:					

REACTION TO SUN EXPOSURE	0	1	2	3	4
What happens when you stay too long in the sun?	<input type="checkbox"/> Painful, redness, blistering, peeling	<input type="checkbox"/> Blistering followed by peeling	<input type="checkbox"/> Burn sometimes followed by peeling	<input type="checkbox"/> Rarely Burn	<input type="checkbox"/> Never had burns
To what degree do you tan?	<input type="checkbox"/> Hardly or not at all	<input type="checkbox"/> Light tan color	<input type="checkbox"/> Reasonable tan	<input type="checkbox"/> Tan very easily	<input type="checkbox"/> Turn dark brown quickly
Do you turn tan within several hours after sun exposure?	<input type="checkbox"/> Never	<input type="checkbox"/> Seldom	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always
How does your face react to the sun?	<input type="checkbox"/> Very Sensitive	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Normal	<input type="checkbox"/> Very Resistant	<input type="checkbox"/> Never had a problem
Total Score for Sun Exposure:					

TANNING HABITS	0	1	2	3	4
When did you last exposure your body to sun, tanning bed or self tanner?	<input type="checkbox"/> More than 3 months ago	<input type="checkbox"/> 2-3 months ago	<input type="checkbox"/> 1-2 months ago	<input type="checkbox"/> Less than a month ago	<input type="checkbox"/> Less than 2 weeks ago
Did you expose the area to be treated to the sun?	<input type="checkbox"/> Never	<input type="checkbox"/> Hardly Ever	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always
Total Score for Tanning Habits:					

SUMMARY	
Total Score for Genetic Disposition:	
Total score for Reaction to Sun Exposure:	
Total score for Tanning Habits:	
Total Skin Type Score:	

SKIN TYPE SCORE	FITZPATRICK SKIN TYPE
0-7	<input type="checkbox"/> I
8-16	<input type="checkbox"/> II
17-25	<input type="checkbox"/> III
25-30	<input type="checkbox"/> IV
Over 30	<input type="checkbox"/> V

Patient or Legal Guardian's Signature: _____

Date: _____



New Patient Information

Office and Financial Policies

We would like to thank you for choosing us for your medical and aesthetic needs. As one of our patients, we would like to keep you informed of the current office and financial policies for this establishment and all subsidiaries*.

Please read each of the following sections carefully and initial:

Insurance:
This establishment and all subsidiaries* do **NOT** participate with any insurance companies. We are not able to bill your insurance and cannot accept payment from insurance for the services performed or prescriptions received. The medical providers do not use diagnosis codes or CPT codes, and because of this, we are unable to complete forms for patient reimbursement from insurance companies.

Initial: _____

Payment:
ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE, however, some services may require a deposit in advance. This establishment and all subsidiaries* only accepts payment in the form of cash, VISA, MasterCard, American Express or Discover, Advance Care Card and Care Credit. **WE do NOT accept checks.**

Initial: _____

*Care Credit cannot be combined with any offer, special or discount, and minimum purchase required.

Refund Policy:
ALL SALES ARE FINAL. Before a service is performed please consider all the required protocols and side effects. We are committed to patient satisfaction and are available to answer any questions or concerns you may have in regards to the services we offer.

Initial: _____

Appointments:
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We require a 24 hour notice for canceling or rescheduling of any appointment. **There is a charge of \$50.00 to \$150.00 per hour for missed or late-canceled appointments.** Excessive abuse of scheduled appointments may result in discharge from the practice.

Initial: _____

Guarantee:
As in any procedure, treatment or program, there is no guarantee of any particular results. Results will vary based on each individual patient.

Initial: _____

Electronic Recording:
To ensure confidentiality and privacy, the use of any type of recording device by a patient while in any of our offices is strictly prohibited. This includes the use of cameras, audio recording devices and camera phones. Using these devices breaches the confidentiality rights of patients and infringes on the privacy rights of our employees. Patients are welcome to take notes during their office visits. Additionally, all conversations between the medical provider and patient are documented in the patient's medical chart. To review this information, a patient may request a copy of their medical records.

Initial: _____

Services Policy:
I understand that this establishment and all subsidiaries* have the right to refuse treatment to and/or dismiss a client from any service, at any time. I also understand that I may not be a candidate for certain services and it is at the full discretion of the aesthetician/medical provider to determine whether I am a candidate for any service provided.

Initial: _____

I have read, understand and agree to the office and financial policies set forth by this establishment and all subsidiaries*.

Patient or Legal Guardian's Signature: _____

Date: _____

Patient's Name (Please Print): _____

At your request, a copy of these policies can be provided for you.



New Patient Information

Notice of Privacy Practices

In accordance with HIPAA federal regulations, this establishment and all subsidiaries* will not disclose any information about you or your personal health, without your permission. All information received while a patient (and if/when you decline to be a patient no longer) will be kept confidential.

Patient Consent for Use and Disclosure of Protected Health Information

By signing this form, you consent to the use and disclosure of your protected health information by our staff, and our business associated **strictly for the purpose of treatment, payment and health care operations.**

You acknowledge you have had an opportunity to review our **Notice of Privacy Practices** prior to signing this consent. We encourage you to review our **Notice of Privacy Practices** carefully. It provides more detail on how we may use and disclose of your information. The **Notice of Privacy Practices** may change. A current copy may be requested when you are being seen as a patient, by contacting our office manager.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing; however, we reserve the right to deny your request. If we grant your request, we are bound by the terms of agreement.

You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment or health care operations. Refer to the **Notice of Privacy Practices** for further information.

By signing this form, I grant my consent for the practice to use and disclose my protected health information **for the purposes of treatment, payment and health care operations.**

Patient or Legal Guardian's Signature: _____

Date: _____

Patient's Name (Please Print): _____

For Practice Use Only:

For Practice Use Only:

Check the appropriate reason:

- Indirect Treatment Relationship
- Emergency Treatment
- Substantial Communication Barrier
- Refusal to Sign

Description: _____

Practice Signature: _____

Date: _____

Witness: _____

Date: _____



New Patient Information

Cancellation Policy

I understand that I am responsible for the following fees, if a 24 hour notice to reschedule or cancel my appointment is not given. These fees also apply to missed appointments.

- Weight Loss Appointments: \$25.00
- Hormone Treatment Appointments: \$50.00
- Injectable Appointments: \$50.00
- Aesthetic Appointments: \$50.00
- Body Contouring: \$150.00/Treatment Hour

I understand that I will be billed for this fee and payment is due before I can reschedule my next appointment.

Patient or Legal Guardian's Signature: _____

Date: _____

Patient's Name (Please Print): _____