Tele:

Artistry Skin and Laser - Demographic and Photo Consent Sheet

Name: ______________________________ Date of Birth: ______________

Phone (Cell): ______________________ (Home): ______________________

Address: ____

City: ______________________ State: ______ Zip: ____________

Email: ____

Emergency Contact: ______________________ Relationship: ______________________

Emergency Contact Phone Number: ______________________________

How did you hear of us?

◯ Drive-by ◯ Google or other search engine?

◯ Our Website ◯ An advertisement ◯ Social Media: ______________________

◯ Doctor referral: ______________________

◯ Business referral: ______________________

◯ Staff referral: ______________________

Photo Consent

Yes	No	
◯	◯	I consent to allow the use of my photos, with no references to my name, wherever Artistry Skin and Laser would like to use it. That may include in-office, Facebook, or commercial advertisements including Artistry Website.
◯	◯	I consent to allow the use of my photos, with no references to my name, for in-office viewing only. This may include a printed before and after photo book, a computerized slide show of before and after photos, or for classroom purposes.

Tele:

Artistry Skin and Laser - Patient Intake Form

Which of the following services have already been provided for you, and when?
Month/ Year

Botox/Filler: ______	Microneedling: ______	Hormones: ______
Coolsculpting: ______	Sclerotherapy: ______	Weight Loss: ______
Chemical Peels: ______	Laser: ______	GI Issues: ______
Facials/Microderm: ______	Neck Treatments: ______	Stress Issues: ______
Kybella: ______	Vein Removal: ______	
Laser Hair Removal: ______		

What additional services would you be interested in learning more about?

Face	Body	Health
☐ Botox/Filler	☐ Brown Spots	☐ B12 Injections
☐ Brown Spots	☐ Excessive Sweating	☐ GI Issues
☐ Hooded Eyes	☐ Fat loss	☐ Hormones
☐ Jowls/Neck Fat Removal	☐ Laser Hair Removal	☐ Muscle Strength
☐ Laser Hair Removal	☐ Loose or Wrinkled Skin – Neck and/ or Chest	☐ Sleep Issues
☐ Red Skin	☐ Red Freckles	☐ Stress Management
☐ Sagging Skin	☐ Stretch Marks/Scars	☐ Weight Loss
☐ Skin Care Advice	☐ Vaginal Tightening	☐ Other: ______
☐ Skin Texture	☐ Veins	
☐ Wrinkles	☐ Other: ______	
☐ Other: ______		

Do you suffer from hot flashes or night sweats? ◯Yes ◯No

Do you have trouble falling asleep? ◯Yes ◯No

Do you have trouble staying asleep? ◯Yes ◯No

Do you feel down, sad, on the verge of tears at times? ◯Yes ◯No

Do you feel physically or mentally exhausted? ◯Yes ◯No

Do you feel loss of sexual desire? ◯Yes ◯No

Do you have bladder issues? ◯Yes ◯No

Do you suffer joint or muscular pain? ◯Yes ◯No

What are you allergic to? ______________________________

What type of reaction do you have to that allergen? ______________________________

Women only:

Any recent changes to or from your contraceptive treatment? ◯No ◯Yes

If so, what and when?

____

Are you pregnant? ◯No ◯Yes Are you breastfeeding? ◯No ◯Yes

Current diagnoses or medical conditions:

Current medications or supplements:

In the last 2 weeks have you used: ☐ aspirin ☐ ibuprofen or other NSAID

Do you get cold sores? ◯No ◯Yes

Have you ever used Accutane? ◯No ◯Yes When? ______________

Any recent surgery, including plastic surgery? ◯No ◯Yes

Explain: ______________________________

Any skin cancer? ◯No ◯Yes

Explain: ______________________________

Do you smoke? ◯No ◯Yes Use recreational drugs? ◯No ◯Yes

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma?

◯No ◯Yes Describe: ______________________________

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

Anything in particular you would like the providers to know or would like to discuss?

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may resulting contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Printed Name: ______________________________

Signature: ______________________________ Date: ____________________

For more information on hormone pellets please scan here:

For more information on FemTouch vaginal rejuvenation: https://lumenis.com/aesthetics/products/femtouch/

For more information on CO2 skin resurfacing: https://lumenis.com/aesthetics/products/acupulse/

For more information on Saliva Cortisol Testing: https://www.zrtlab.com/test-specialties/stress-hormones/

For more information on stool testing: https://www.biomefx.com/gut-microbiome-health

For more information on weight loss with semaglutide: https://www.drugs.com/semaglutide.html

Tele:

Please Select an answer for each row

FITZPATRICK QUIZ

Fitzpatrick Skin Type Questionnaire					
Score	**0**	**1**	**2**	**3**	**4**
Eye colour?	◯ Light blue, gray or green	◯ Blue, gray or green	◯ Blue	◯ Dark brown	◯ Brown/black
Natural hair colour?	◯ Red	◯ Blonde	◯ Chestnut, dark blonde	◯ Black	◯ Dark brown
Non-exposed skin color?	◯ Reddish	◯ Very pale	◯ Pale with beige tint	◯ Dark brown	◯ Light brown
Freckles on non-exposed skin?	◯ Many	◯ Several	◯ Few	◯ None	◯ Incidental
Long sun exposure with no sun block?	◯ Blisters, redness, peeling	◯ Burn followed by peeling	◯ Burn sometimes then peels	◯ Never burn	◯ Rarely burn
What degree tan?	◯ Hardly at all	◯ Light colour tan	◯ Reasonable tan	◯ Dark brown tan	◯ Tan very easily
Turn brown within several hours?	◯ Hardly ever to not at all	◯ Seldom	◯ Sometimes	◯ Always	◯ Often
Facial sun reaction with no block?	◯ Very sensitive	◯ Sensitive	◯ Normal	◯ Never had a problem	◯ Very resistant
When were you last exposed to the sun?	◯ More than 3 months ago	◯ 2-3 months ago	◯ 1-2 months ago	◯ Less than 2 weeks ago	◯ Less than 1 month ago
Is the treatment area exposed to the sun?	◯ Never	◯ Hardly ever	◯ Sometimes	◯ Always	◯ Often

◯ Score 1-7 Type I	◯ Score 8-16 Type II	◯ Score 17-25 Type III	◯ Score 26-30 Type IV	◯ Score 30+ Type V-VI

HIPPA Information & Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides a safeguard to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1. Client information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers as necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, client records, PHI and other documents or information.
2. It is the policy of this office to remind clients of their appointments. We may do this by telephone, e-mail, US mail, text, or any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology, as well as our office promotional material that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI, but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. We agree to provide client's access to their records in accordance with state and federal laws
7. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the client.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____ (name) do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: ________________________________ Date: ____________________