Seacoast Rejuvenation Center

Client Information

Date _____

Patient Name _____
FIRST **MIDDLE** **LAST**

Name you prefer to be called_____

Address _____

_____

_____You may contact me by US mail.

Date of Birth _____ Sex_____M_____F Age _____

Home Phone Number _____Cell Phone Number_____

Work Phone Number _____ ext._____

I prefer to be contacted at my home / cell / work phone number (please indicate).

_____You may contact me at either number.

E-mail address_____ ____You may contact me via e-mail.

Name and address of your Primary Care Physician

_____

If the patient is a minor, name and address of parent or guardian

_____

HOW WERE YOU REFERRED TO *SEACOAST REJUVENATION CENTER*?

_____ Yellow pages *
_____ Newspaper *
_____ Friend or relative *
_____ Physician *
_____ Mailing or newsletter
_____ web site - www.seacoastrejuvenation.com
_____ other web site *
_____ TV
_____ other *

* Please specify _____

CONSENT TO BE PHOTOGRAPHED

I consent to be photographed before, during and after my treatment. I understand that these photographs shall be the property of ***Seacoast Rejuvenation Center*** as a part of my permanent patient record.

Signature of Patient, Parent or Guardian _____

CONSENT TO USE PHOTOGRAPHS

I understand and agree that my photographs may be used for scientific purposes, for internal patient education, publication, and presentations. I understand my identity will be protected.

Signature of Patient, Parent or Guardian _____

CONFIDENTIALITY AGREEMENT

I understand my records and photographs are strictly confidential. The contents of my records cannot be released to any person or organization without my prior written approval, excluding peer review.

Signature of Patient, Parent or Guardian _____

SEACOAST REJUVENATION CENTER, PLLC

Thank you for choosing **Seacoast Rejuvenation Center** for your aesthetic needs. **Seacoast Rejuvenation Center** is dedicated to providing the highest quality care in the areas of cosmetic non-surgery, as well as clinical skin-care.

The following is intended to outline the financial policies of our practice and to ensure your understanding of these policies. After reading this information, please sign below. If you have any questions, please do not hesitate to ask.

PAYMENT POLICY

Full payment for any service is required at the time of service. For your convenience, we accept, cash, certified bank checks, and all major credit cards. **Seacoast Rejuvenation Center** does not participate with any insurance carriers. We will not submit information, (codes, notes, pictures, etc.), on your behalf to any insurance company.

Initial appointments must be reserved with a credit card. No charge will be placed on the card unless the appointment is missed without notification.

If it is necessary for you to cancel or reschedule your appointment, **Seacoast Rejuvenation Center** must receive at least 24 hour notice of that change. There will be an administrative fee for appointments cancelled with less than 24 hour notification and for missed appointments. The fee will be equal to 50% of the regular cost of the scheduled appointment. You will have 30 days to reschedule. If you miss a groupon appointment you either lose one appointment if there are multiple appointments involved, or you lose your groupon.

FINANCIAL POLICY FOR COSMETIC PROCEDURES

All treatments will be charged on the day of service. We accept, certified bank checks, money orders, cash and all major credit cards. If paying by credit card, the card must be presented in person by the authorized cardholder and a charge slip must be signed.

If you would like to explore financing options, we offer Care Credit.

YOUR COSMETIC CONSULTATION

To ensure your safety and satisfaction, our Doctor will review your medical history, discuss your areas of concern and treatment options and we will take pictures of those areas. We will discuss any pre-procedure considerations, including the anticipated recovery period, and explain the breakdown of fees and the total cost.

_____

PATIENT NAME (PRINTED)

_____ _____

PATIENT SIGNATURE (OR GUARANTOR IF PATIENT IS A MINOR **DATE**

Seacoast Rejuvenation Center

Clinical Skin Evaluation

Have you ever seen a dermatologist for your skin? ☐ yes ☐ no

Have you ever or are you currently taking any of the following medications?

_____ **Coumadin** _____ **Accutane** _____ **Minocyn** _____ **Aspirin**

If yes, when?_____

Have you ever had cold sores?_____ Have you ever had genital herpes?_____

If yes, when was your last outbreak?_____

Have you ever had a **skin allergy**? (i.e. cosmetics, fabrics, latex, salicylic or glycolic acids, etc.) ☐ yes ☐ no

If yes, please explain._____

Microdermabrasion should be avoided for individuals with **HIV, uncontrolled diabetes, suspected TB or pregnancy**. Is there a possibility that you may have one of these conditions?

_____ Yes _____ No If yes, please explain._____

Would you describe your pigmentation as: Even Uneven Birthmark Pregnancy Mask (Melasma)

Do you have broken capillaries? ☐ yes ☐ no Nose Cheeks Chin Forehead Entire Face

Do you have acne or periodic breakouts? ☐ yes ☐ no

Pimples Whiteheads Blackheads Enlarged Pores Flakiness Acne Scars

Do you have: Deep Wrinkles Crows Feet Fine Lines

Skin Type (Fitzpatrick Classification)
Please circle the category that you feel is accurate.

I. Always burn, never tan
II. Always burn first, then tan
III. Sometimes burn, sometimes tan
IV. Never burn, always tan
V. Hispanic, Asian, Mediterranean, Middle Eastern
VI. Black

Do you wear contact lenses? ☐ yes ☐ no

Do you form thick or raised scars from a cut or burn? ☐ yes ☐ no

Do you use a sun block when outdoors? ☐ yes ☐ no

What SPF do you use? _____

Do you use chemical self-tanning lotions? ☐ yes ☐ no

Have you or members of your family had skin cancer? ☐ yes ☐ no Location _____

Have you ever had any of the following hair removal treatments? bleach electrolysis epilation wax pluck shave

When was your last hair removal treatment? _____

Have you had Botox or any type of filler injection within the last 2 weeks? _____ Yes _____ No

Have you undergone Laser Resurfacing with the past 12 weeks? _____ Yes _____ No

Have you had a glycolic or TCA peel within the past 8 weeks? _____ Yes _____ No

How do you wish to improve your skin? _____

_____

Seacoast Rejuvenation Center

Medical Evaluation Form

Name _____ **Date**_____

Age_____ **Gender** **M / F** **Height**_____ **Weight**_____

***Allergies**—list both drug & environmental (penicillin, local anesthetic, topical products or **LATEX**)

_____

1. Please describe your reasons for seeking consultation: _____

_____

2. Medical History:

☐ yes ☐ no **Skin Disorders**: (Cancer, rosacea, rashes, burns, scars, keloid)
If yes, please describe _____

☐ yes ☐ no **Endocrine** (Diabetes, hyper/hypothyroidism)
If yes, please describe _____

☐ yes ☐ no **Bleeding disorders** (frequent bruising, abnormal bleeding, coumadin)
If yes, please describe _____

☐ yes ☐ no **Immune** (Herpes/Cold Sores, Hepatitis B/C, HIV etc)
If yes, please describe _____

☐ yes ☐ no **Neurological** (headaches, neck, back or extremity pain/tremors, seizures
If yes, please describe _____

☐ yes ☐ no **Eyes, Ears** (cataracts, glaucoma, tinnitus, hearing impaired, dizziness)
If yes, please describe _____

☐ yes ☐ no **Nose ,Throat** ((allergies, snoring, sinus infections strep throat)
If yes, please describe _____

☐ yes ☐ no **Lungs** (asthma, emphysema, bronchitis, shortness of breath)
If yes, please describe _____

☐ yes ☐ no **Heart** (MVP, irregularities, angina, high blood pressure, chest pain)
If yes, please describe _____

☐ yes ☐ no **Digestive** (indigestion, reflux, ulcers, colitis)
If yes, please describe _____

☐ yes ☐ no **Menstrual Cycle** (regular, irregular, degree of cramps, rate of flow)
If yes, please describe _____

☐ yes ☐ no **Urinary** (bladder infections, bladder control, blood in urine)
If yes, please describe _____

☐ yes ☐ no **Mental Status** (anxiety, depression, eating disorder)
If yes, please describe _____

Do you have any **contraindications** for these procedures? (Please circle.)

Thermage
- Pacemaker
- Defibrillator
- Metal implants
- Pregnancy

GentleWaves
- Seizures
- Migraines triggered by light
- Pregnancy

Microdermabrasion
- Rash
- Roseacea
- Cold sores
- Pregnancy

ClearLight
- Accutane use in the last 6 months
- Light-sensitizing medications
- Pregnancy

Mesotherapy
- Allergies to lidocaine or meds

3. Medications:

List all prescription, over the counter and herbal supplements with dose and frequency.
Include topical medications (Retin A, Glycolic Acid, etc.)

Medication
1.
2.
3.
4.
5.
6.

4. Surgery:

List all surgeries with date and any complications:

Surgery	*Date*	*Complications*
1.		
2.		
3.		

5. What type of work do you do? (inside or outside the home, please describe)

_____

6. Do you smoke? (what and how much per day)

_____

7. Do you drink alcohol? (how frequently)

_____

8. What types of foods do you eat?

_____

9. Make a list of the various aspects of wellness that are important to you:
(e.g., prevention of disease, aging, mood control, weight control, libido, etc.)

_____

_____

_____

_____

Do you have any **contraindications** for these procedures? (Please circle.)

Photorejuvenation/IPL

- Light-sensitizing medications or Accutane
- Seizures
- Cold sores
- Permanent makeup/tattoo
- Diabetes
- Keloid scars
- Tan/Sun exposure in the last 2 weeks
- Glycolic acid products in the last 3 days
- Coumadin, aspirin or anti-inflammatory meds
- Pregnancy

Laser Treatments

- Coumadin aspirin or anti-inflammatory use
- Tan/Sun exposure in the last 2 weeks
- Diabetes
- Keloid scars
- Cold sores or Herpes
- Accutane in the last 6 months
- Tattoos
- Waxing in the last month
- Pregnancy

Botox / Restylane

- Cold sores
- Neurologic illness-Botox
- Albumin allergy (Botox)
- Coumadin,aspirin or aminoglycoside use
- Pregnancy