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? (please circle)
Drive-by Attitudes and Hair Google or other search engine?
Our Website An advertisement Social Media :________________________
Doctor referral: _______________________________
Client referral: ________________________________
Business referral:______________________________
Staff referral:________________________________

Photo Consent

Please initial next to **ONE** only please:

____ 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.

___ I consent to the allow the use of my photos, with no references to my name, on the Artistry Skin and Laser website and for in-office viewing.

___ I consent to allow the use of my photos, with no references to my name, for in-office viewing only. That may include a printed before and after photo book, a computerized slide show of before and after photos, or for classroom purposes.

___ I do not want my photographs shared with anyone.

Artistry Skin and Laser - - - Patient Intake Form

Name:___________________________

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

Skin Care Advice:_______________	Microblading: _______________	Sagging Skin:________________
Botox/Filler:___________________	Microneedling: ______________	Facial Redness:______________
Chemical Peels: ________________	PRP: ______________________	Brown Spots: _______________
Facials/Microdermabrasion: ______	Sclerotherapy: ______________	Eyelash Extensions: __________
Kybella:______________	Laser: _____________________	Neck Wrinkles:______________
Laser Hair Removal:_____________	Waxing:____________________	Other:_____________________

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

❑ Skin Care Advice	❑ Microblading	❑ Sagging Skin
❑ Botox/Filler	❑ Microneedling	❑ Facial Redness
❑ Chemical Peels	❑ PRP	❑ Brown Spots
❑ Facials/Microdermbrasion	❑ Sclerotherapy	❑ Eyelash length/fullness
❑ Kybella	❑ Laser	❑ Neck Wrinkles
❑ Laser Hair Removal	❑ Waxing	❑ Other:_______________

Current diagnoses or medical conditions:____
____
____

Current medications or supplements:____
____

In the last 2 weeks have you used (circle): aspirin ibuprofen or other NSAID

Have you ever used Accutane? ____No ____Yes … When?_________________________

Any recent surgery, including plastic surgery? ____No ____ Yes
Explain: ____

Any skin cancer? ____No ____Yes … When?______________________________________
Explain: ____

Do you smoke? ____No ____Yes Use recreational drugs? ____No ____Yes

Do you get 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

What are you allergic to?____

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

Women only:
Any recent changes to your contraceptive treatment? ____ No ____ Yes
If so, what and when? ____

Are you pregnant? ____No ____Yes Are you breastfeeding? ____ 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:_______________________________________ Date:______________________

Signature (Self, or Guardian if patient is less than 18):___________________________________

Please Circle 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	Dark brown	Black
Non-exposed skin color?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
Freckles on non-exposed skin?	Many	Several	Few	Incidental	None
Long sun exposure with no sun block?	Blisters, redness, peeling	Burn followed by peeling	Burn sometimes then peels	Rarely burn	Never burn
What degree tan?	Hardly at all	Light colour tan	Reasonable tan	Tan very easily	Dark brown tan
Turn brown within several hours?	Hardly ever to not at all	Seldom	Sometimes	Often	Always
Facial sun reaction with no block?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
When were you last exposed to the sun?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
Is the treatment area exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always

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 record, 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 many 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.

   You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor,
5. We agree to provide client's access to their records in accordance with state and federal laws.
6. We may change, add, delete, or modify any of these provisions to better serve the needs of both 'the practice and the client.

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:__________________