Gulf Coast Medical Center
DERMATOLOGY & AESTHETICS

Patient Intake Form

Name (Last, First) _____________________________, __________________________________ Today's Date ____________________

Date of Birth: ___________________________ Age: ________ Gender: __________________________________

Address: ____

City: ____ State: ____________________ Zip: _______________________

Phone: Mobile: ______________________________ Home: _______________________________ Work: _______________________

Best number to leave any confidential information regarding your treatment and messages: (please circle) *Mobile* *Home* *Work*

E-mail address (please print clearly): ____

How did you hear about us? ____

Marital Status (please circle): *Single* *Married* *Widowed* *Divorced*

Occupation/Employer: ____

Ethnicity (please circle): *Caucasian* *Hispanic* *African American* *Asian* *Middle Eastern* *Middle Eastern* *Pacific Islander* *Other: ____________* *Prefer not to answer*

(Note: Ethnicity, national origin and race may affect how skin reacts to laser/IPL treatment)

Emergency Contact Name: ________________________________ Relationship to you: _____________ Phone Number: ____________

Primary Care Physician: ______________________________________ Phone Number: ______________________________________

--DETAILED MEDICAL HISTORY--

[OFFICE USE ONLY]

Skin Conditions (Psoriasis, Eczema, Scars, etc.): *NO* *YES* (If YES, explain) ______________________________

Heart Disease (Heart Attack, Palpitations, etc.): *NO* *YES* (If YES, explain) ______________________________

Neurological Disease (Seizures, Epilepsy, etc.): *NO* *YES* (If YES, explain) ______________________________

Lung Disease (COPD, Asthma, etc.): *NO* *YES* (If YES, explain) ______________________________

Liver/Kidney Disease (Cirrhosis, Hepatitis, etc.): *NO* *YES* (If YES, explain) ______________________________

Cancer (Leukemia, Lymphoma, Melanoma, etc.): *NO* *YES* (If YES, explain) ______________________________

Digestive Problems (IBS, Diarrhea, etc.): *NO* *YES* (If YES, explain) ______________________________

Hypertension/Vascular disease (DVT, etc.): *NO* *YES* (If YES, explain) ______________________________

Trauma (serious car accidents, injuries, etc.): *NO* *YES* (If YES, explain) ______________________________

Infectious Disease (Tuberculosis, STDs, etc.): *NO* *YES* (If YES, explain) ______________________________

Immunosuppression (HIV, AIDS, etc.): *NO* *YES* (If YES, explain) ______________________________

Endocrine Disorder (Thyroid, Diabetes, etc.): *NO* *YES* (If YES, explain) ______________________________

Mental Illness (Depression, Suicide, Bipolar, etc.): *NO* *YES* (If YES, explain) ______________________________

Any OTHER medical problems: *NO* *YES* (If YES, explain) ______________________________

List ALL current MEDICATIONS: ____

____

List ALLERGIES: ____

[OFFICE USE ONLY]: ____ [STAFF SIGNATURE]: ___________________________________

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Question		
Do you have an allergy to Bacitracin®, Polysporin®, Neosporin® or any other topical antibiotic cream?	*NO*	*YES*
Do you have an allergy to any topical anesthetics such as Benzocaine, Tetracaine or Lidocaine?	*NO*	*YES*
Have you used Accutane®, Claravis®, Sotret® or Amnesteem® (Isotretinoin) in the last six months?	*NO*	*YES*
Do you have a history of herpes simplex ("cold sores" or "fever blisters") or infection in area to be treated?	*NO*	*YES*
Female patients only: Are you pregnant or breast-feeding?	*NO*	*YES*
Female patients only: Do you take any kind of birth control?	*NO*	*YES*

Last Sun Exposure (tanning / outdoor activity): ____

Do you use tanning beds or spray-on tanning? *NO* *YES* Last exposure: ____

Do you smoke? *NO* *YES* If YES, how much and how often? ____

How does your skin react when exposed to the sun? (Please circle only ONE of these six choices below)

Always Burns & Never Tans	Burns Easily & Tans Minimally	Sometimes Burns & Slowly Tans	Burns Minimally & Usually Tans	Rarely Burns & Tans Well	Never Burns & Always Tans

---SELECT SKIN TYPE---

Please circle the Skin Type that matches your features and Reaction to UV (30 minutes of sunlight without SPF)

Skin Type	Common features	Reaction to UV*
I	Very fair / blue eyes / freckles	Always burns, never tans
II	Fair / blue, hazel or green eyes	Always or usually burns, tans with difficulty, tan fades rapidly
III	Cream white / fair with any eye or hair color / very common	Sometimes mild burn, always or usually tans, tan stays for weeks
IV	Brown / typical Mediterranean skin / moderately pigmented and may include Asian, Middle Eastern, Indian, Hispanic	Rarely burns, tans with ease, tan stays for months
V	Darker brown / darker skin type and may include Asian, Middle Eastern, Indian, Hispanic, Mediterranean (non-Caucasian)	Very rarely burns, tans very easily
VI	Darkest brown, black (non-Caucasian)	Never burns, tans very easily

Adapted from Fitzpatrick TB The Validity and Practicality of Sun-Reactive Skin Types I through VI Arch Dermatol-Vol 124, June 1988.

--SELECT SERVICES OF INTEREST--

Are there any other services that you are interested in?

Injectables			**What are your skin concerns**	
☐	BOTOX®/Dysport®/Jeuveau®		☐	Acne
☐	Fillers		☐	Discoloration / Uneven Skin Tone
			☐	Hyperpigmentation / Sun Damage
Lasers			☐	Fine Lines / Wrinkles
☐	Pigmentation		☐	Texture
☐	Laser Sun Spot Removal		☐	Rosacea
☐	Acne Treatment		☐	Dryness
☐	Broadband Light – BBL™		☐	Other:
☐	MOXI™			
			Optional Services	
Skin Services			☐	IV Nutritional Therapy
☐	HydraFacial®		☐	Weight Loss
☐	DermaPeel			
☐	Chemical Peel			
☐	Facial Services			
☐	Microneedling			
☐	SkinPen®			

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Gulf Coast Medical Center
DERMATOLOGY & AESTHETICS

POLICIES, PROCEDURES, AGREEMENTS and CONSENTS

The next two pages are intended to provide you with detailed information about our policies, programs, agreements and consents. Please read each section thoroughly, make sure any concerns are addressed and that any questions you have are answered before making your final decision to move forward with the treatment process.

HIPAA PATIENT CONSENT

Our office is committed to protecting the privacy of your medical information. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (and updated in 2013) is a federal law that governs the use and disclosure of a person's health information. Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. The Notice contains a "Patient Rights" section describing your rights under the law. The following statements cover the basics of your rights as a patient under HIPAA:

- Our office has a "Notice of Privacy Practices" and you have the right to review a detailed copy of our Notice before signing this HIPAA Patient Consent.
- This "Notice of Privacy Practices" is available in our offices.
- Protected health information may be disclosed for treatment, payment, or health care operations.
- We reserve the right to change the terms of our "Notice of Privacy Practices" at any time.
- If we change our Notice, you may obtain a revised copy by contacting our office.
- You have the right to restrict the uses of your protected health information.
- You may revoke this HIPAA Consent in writing at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Additionally, it is the policy of this office to remind patients of their appointments. We may do this via live telephone calls, automated appointment reminder calls, text messages, e-mails, or by any means convenient to the practice. We may also send you other communications informing you of changes to office policy, new technology and specials that you might find valuable or informative. That said, contact will only come directly from us; we will never sell or trade your private information including phone numbers, e-mail address or mailing addresses. You may opt out of any or all communication measures any time by contacting us in writing.

By signing the next page of this document, you certify that you have read our HIPAA Patient Consent and have had the opportunity to review a more detailed version if so desired. Your signature also signifies that you agree with the above statements and this policy. GULF COAST MEDICAL CENTER DERMATOLOGY AND AESTHETICS provides this form and information in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (updated in 2013).

TELEHEALTH (TELMEDICINE) CONSENT and VIDEO/PHOTO AGREEMENT

My signature below certifies that I understand, agree and consent that GULF COAST MEDICAL CENTER DERMATOLOGY AND AESTHETICS and its employees, independent contractors, associates, agents and representatives (collectively and hereby known as, "Gulf Coast Medical Center Dermatology and Aesthetics",) may take photographs and/or use video (for "store & forward" or teleconferencing technology) of the area to be treated before initial treatment begins & at some or all reoccurring visits (genital area photos and videos are usually NOT taken). These recordings will be available only to our medical staff members to assess the patient and track the progression of each treatment and are part of the medical record. GULF COAST MEDICAL CENTER DERMATOLOGY AND AESTHETICS follows extremely strict HIPAA guidelines regarding patient confidentiality and privacy & therefore names and recordings are used internally and only the treated area/area to be assessed will be shown in these photographs & videos.

Print Patient Name: ____

Patient Signature: ____ Date: ___________________

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----------APPENDIX APPOINTMENT POLICY----------

Gulf Coast Medical Center Dermatology and Aesthetics strives to treat all clients at their scheduled times. Keeping your appointments allows for better results because you are able to stay on your treatment schedule. Additionally, no-shows block out otherwise available slots for other patients to get in to maintain their scheduled treatment plans.
Patients must provide 24 hours' notice if they need to reschedule or are unable to make their appointment.

- Patients must pay a $25.00 "no show" / "late cancellation" fee if they miss an appointment or do not give 24 hours' notice of a cancellation or re-schedule.
- If the provided credit card declines, Gulf Coast Medical Center Dermatology and Aesthetics will penalize by applying the treatment areas scheduled on the day of the no-show as used.

*__As a courtesy to our patients, we send out email and text reminders. However, not receiving those reminders will not excuse a missed appointment.__

Please choose Option 1 or Option 2

Option 1: You may pay the fee prior to your next scheduled appointment. You will not be seen if the fee has not been paid and the appointment will be rescheduled.

Option 2: You may apply for CareCredit or a payment arrangement with our Billing Department.

My signature below indicates that I understand Gulf Coast Medical Center Dermatology and Aesthetics' no-show policy and that I understand the fees that will be applied should I not provide 24 hours' notice of cancellation prior to my scheduled appointment time.

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

My signature below certifies that I hereby seek the services of Gulf Coast Medical Center Dermatology and Aesthetics, and its employees, independent contractors, associates, agents and representatives (collectively and hereby known as, "Gulf Coast Medical Center Dermatology and Aesthetics",) for laser, cosmetic and/or dermatological care. I understand that injections, chemical peels, and laser treatments, such as BBL and MOXI, are voluntary procedures and are not covered by Medicare, Medicaid, Medi-Cal, HMO, PPO, or private insurance plans. I understand that Gulf Coast Medical Center Dermatology and Aesthetics will not submit any claims to any insurance carriers. I understand that payment is due before services are rendered. I also understand and agree that if I pay for a package of services using a credit card, check or finance company and the payment is not honored or is subject to a chargeback at any time for any reason that I am still fully responsible for payment for the treatments I receive and agree to pay for them at the undiscounted ("pay as you go") rate. I agree to pay a fee of $25.00 for each check or charge that is not honored by my bank. Lastly, I fully acknowledge that I am personally responsible for all fees and charges incurred in connection with my purchase and I completely understand that there is absolutely **NO** refunding of any patient fees, payments, charges, credit, gift certificates, product purchases or pre-paid packages.

✖	✖
PRINTED NAME OF PATIENT	**TODAY'S DATE**
✖	
PATIENT SIGNATURE (or signature of legal guardian if patient is under 18)	This space for office use only (Staff Signature)

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