

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Sex: M / F

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Please put a check mark next to the items that are cosmetically displeasing to you:

- |                                                   |                                             |
|---------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Acne Troubles            | <input type="checkbox"/> Shaving Bumps      |
| <input type="checkbox"/> Wrinkles                 | <input type="checkbox"/> Brown Spots        |
| <input type="checkbox"/> Sun Damage               | <input type="checkbox"/> Rosacea            |
| <input type="checkbox"/> Cellulite or fat pockets | <input type="checkbox"/> Broken Capillaries |
| <input type="checkbox"/> Skin Texture and Toning  | <input type="checkbox"/> Spider Veins       |
| <input type="checkbox"/> Sagging Skin             | <input type="checkbox"/> Chin Fullness      |

Please put a check mark next to any past or current medical conditions:

- |                                                                         |                                                            |
|-------------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Lupus of other auto-immune disorder            | <input type="checkbox"/> Diabetes                          |
| <input type="checkbox"/> Dark Spots after pregnancy or skin injury      | <input type="checkbox"/> Epilepsy                          |
| <input type="checkbox"/> Accutane treatments with in the last year      | <input type="checkbox"/> Scars that turn white or brown    |
| <input type="checkbox"/> Tetracycline treatments with in the last month | <input type="checkbox"/> Cystic Acne                       |
| <input type="checkbox"/> Keloid or very thick scarring                  | <input type="checkbox"/> HIV/AIDS                          |
| <input type="checkbox"/> Blepharoplasty (eyelid surgery)                | <input type="checkbox"/> Hepatitis                         |
| <input type="checkbox"/> Pulmonary embolism/blood clot                  | <input type="checkbox"/> Psoriasis or Vitiligo             |
| <input type="checkbox"/> Leg Ulcer or Phlebitis                         | <input type="checkbox"/> Herpes Simplex or fever blisters  |
| <input type="checkbox"/> Blood thinning medications                     | <input type="checkbox"/> Hirsutism                         |
| <input type="checkbox"/> Coumadin or other anti-clotting agents         | <input type="checkbox"/> Transplant/Anti-rejection Drugs   |
| <input type="checkbox"/> Rheumatoid Arthritis "Gold" Therapy            | <input type="checkbox"/> Bleeding abnormalities            |
| <input type="checkbox"/> Abnormal Heart Conditions                      | <input type="checkbox"/> High or Low Blood Pressure        |
| <input type="checkbox"/> Fainting Spells / Dizziness                    | <input type="checkbox"/> Circulatory Problems              |
| <input type="checkbox"/> Cancer                                         | <input type="checkbox"/> Chemotherapy/Radiation Treatments |
| <input type="checkbox"/> Do you have any Implantable Devices?           | <input type="checkbox"/> Cryoglobulinemia                  |
| <input type="checkbox"/> Cold agglutinin disease                        | <input type="checkbox"/> Paroxysmal cold hemoglobinuria    |

Are you pregnant or think that you may be pregnant? \_\_\_\_\_

Are you currently breast feeding? \_\_\_\_\_

List any drug, makeup, skin, **soy** or other food allergies: \_\_\_\_\_

Do you get pigment or brown spots from an injury, insect bite or cut? \_\_\_\_\_

(please turn the page over)

Have you had any recent chemical peels, dermabrasion, laser procedures or plastic surgery? \_\_\_\_\_

What skin care and makeup products do you use for your skin care? \_\_\_\_\_

Are you currently taking Asprin or ibuprofen? \_\_\_\_\_

When were you last exposed to the sun, including tanning booths? \_\_\_\_\_

Do you use a self tanner? \_\_\_\_\_ If so, when did you last apply it? \_\_\_\_\_

Have you tweezed, waxed or had any electrolysis treatments done within the last 4 weeks? \_\_\_\_\_

Are you currently taking any prescription acne medications or having any acne therapies done? \_\_\_\_\_

Please list all medications and herbal supplements that you are currently taking: \_\_\_\_\_

What would you like to discuss in greater detail today with your physician? \_\_\_\_\_

*Thank you for choosing Medical Aesthetics and Laser!*



I hereby authorize Medical Aesthetics and Laser, and its employees, to take and use pictures for the purpose of:  
Proof of results and Medical Aesthetics and Laser marketing.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Today's Date



Medical Aesthetics and Laser  
 9180 Pinecroft Dr., Suite 120, The Woodlands, TX  
 77380

## Fitzpatrick Skin Type

Please complete the following questions by circling the number which best describes you. Your physician will total the score during the consultation.

### Eye Color

- 0. Light Colors
- 1. Blue, grey or green
- 2. Dark
- 3. Brown
- 4. Black

### Natural hair color at age 18 was:

- 0. Sandy Red
- 1. Blond
- 2. Chestnut or dark blond
- 3. Brown
- 4. Black

### Your Skin Color

#### (unexposed areas)

- 0. Reddish
- 1. Pale
- 2. Beige or olive
- 3. Brown
- 4. Dark Brown

### Freckles (unexposed areas)

- 0. Many
- 1. Several
- 2. Few
- 3. Rare
- 4. None

### If you stay in the sun too long?

- 0. Painful blisters, peeling
- 1. Mild blisters, peeling
- 2. Burn, mild peeling
- 3. Rare
- 4. No burning

### Do you turn brown?

- 0. Never
- 1. Seldom
- 2. Sometimes
- 3. Often
- 4. Always

### How brown do you get?

- 0. Never
- 1. Light tan
- 2. Medium tan
- 3. Dark tan
- 4. Deep dark

### Is your face sensitive to the sun?

- 0. Very sensitive
- 1. Sensitive
- 2. Sometimes
- 3. Resistant
- 4. Never have a problem

### How often do you tan?

- 0. Never
- 1. Seldom
- 2. Sometimes
- 3. Often
- 4. Always

### When was your last tan?

- 0. +3 months ago
- 1. 2-3 months ago
- 2. 1-2 months ago
- 3. Weeks ago
- 4. Days

If your score is:	Your skin type is:
0 thru 6	I
7 thru 13	II
14 thru 20	III
21 thru 27	IV
28 thru 34	V
35+	VI

Notes:



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## HIPAA Release Form

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Medical Aesthetics and Laser is very serious about our client's confidentiality.

### Release of Information

I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This information may be released to:

- Spouse \_\_\_\_\_
- Child(ren) \_\_\_\_\_
- Other \_\_\_\_\_

Information is not to be released to anyone.

This **Release if Information** will remain in effect until terminated by me in writing.

### Messages

Please call  Home  Work  Cell

If unable to reach me:

- You may leave a detailed message
- Please leave a message asking me to return your call
- \_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



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## Cancellation Policy

### Cancellation/ Rescheduling of an Appointment

Please contact Medical Aesthetics and Laser at (281) 419-2220 **24 hours** prior to your scheduled appointment date and time to avoid cancellation fees.

Failure to cancel within the required time will result in a fee of **\$25.00** being charged to the credit card on file. A **No Show** is considered failure to cancel or failure to show for a scheduled appointment, a fee of **\$35.00** will be applied to the credit card on file.

### New Clients

If a new client **fails to cancel or reschedule** their appointment time within the **24 hour** time frame they will forfeit **ALL** limited -time pricing offers, monthly special promotions, discounts or coupons.

*We reserve the right to refuse appointments to any client who has demonstrated disregard of our cancellation policy.*

**I understand the cancellation policy and agree to its terms.**

**Client Signature** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Client Name (Please Print)** \_\_\_\_\_

### Debit/ Credit Card Authorization

Cardholders Name (as it appears on card) \_\_\_\_\_

Credit Card Number (list all numbers) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Expiration Date \_\_\_\_\_ CVV\* \_\_\_\_\_

\*CVV is the last 3 digits on the back of your card. For AMEX it's the 4-digit code on the front side.

Master Card  Visa  American Express  Discover

Check box if same as Home Address

Credit Card Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**I agree to be charged in the amount indicated above via debit/ credit card if I fail to follow the cancelation policy as stated by terms set by Medical Aesthetics and Laser.**

**Cardholders Signature** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_