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Spokane, WA 99201
(509) 209-2171

DR. KEVIN JOHNSON'S Advanced Aesthetics

608 Northwest Blvd. Suite 301
Coeur d' Alene. ID 83814
(208) 676-8346

Patient Name _____ Sex: M __ F__ DOB_____ Today's date _____

Address _____ City _____ State _____ Zip _____

Home (_____)_____ Cell (_____)_____ Work (_____)_____ Primary contact number? (H) (C) (W)

Marital Status: (S) (M) (W) (D) Occupation _____ Employer _____

Email Address: _____

Emergency Contact _____ Relation_____ Phone (____) _____

(Y) __ ***(N)*** ___ ***I would like to receive future monthly EMAILS for promotional events, discounts, and specials from Advanced Aesthetics.***
*****Your email address is used strictly for our communication with you and will not be given out. (Signature required on HIPAA form)***

How did you hear about us? Website___ Internet_____ Facebook_____ Email_____ TV Commercial_____ Newspaper_____
Friend/Relative (name)_____ Billboard_____ Radio_____ Other (please specify)_____

HEALTH INFORMATION

Which concerns apply to you? Please circle all that apply.

Unwanted body fat	Unwanted hair	Cellulite	Stretch mark	Vaginal dryness	Urinary Incontinence
Unwanted tattoo(s)	Wrinkles	Upper lip lines	Skin laxity	Scarring	Uneven skin tone
Visible veins	Varicose veins	Enlarged pores	Brown spots	White spots	Dry patches
Clogged pores	Excessive oiliness	Black or Whiteheads			

Other: _____

List all medications you are taking (prescription and over the counter): _____

_____

_____

Do you have any ALLERGIES to medications? ☐ Yes ☐ No If yes, please specify and state type of reactions: _____

_____

Do you have any neuromuscular or autoimmune diseases? ☐ Yes ☐ No If yes, please list: _____

_____

Do you take oral anti-coagulant (blood thinning) medication? ☐ Yes ☐ No Specify: _____

Do you take Aspirin, Advil, Motrin, Ibuprofen, or anti-inflammatory meds more than once a week? ☐ Yes ☐ No If yes, please explain: _____

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No **Do you use oral contraceptives?** ☐ Yes ☐ No

Do you have allergies to latex? ☐ Yes ☐ No **Do you have a fear of needles?** ☐ Yes ☐ No

Please list all surgeries or hospitalizations with dates: _____

_____

Have you had any cosmetic procedures in the past? Please list with dates: _____

_____

Are you allergic to any cosmetic ingredients or foods? ☐ Yes ☐ No If yes, please list: _____

_____

Do you smoke? ☐ Yes ☐ No If yes, how many per day _____ How many years _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much _____ How often _____

Do you have or have ever had any of the following (please circle):

Asthma	Arthritis	Anemia	Autoimmune disorder	Blood disorder	Chest pain
Clotting disorder	Diabetes	Depression	Easy bruisability	Excessive scarring	Excessive bleeding
Gold Therapy	Heart attack	Heart failure	Heart valve disease	Heart valve replacement	High blood pressure
Hormonal problems	HIV	Irregular heart beat	Intestinal problems	Impaired skin sensation	Impaired circulation
Keloids (scars)	Kidney disease	Liver disease	Lung disease	Multiple Sclerosis	Muscular dystrophy
MVP	Migraines	Open Infected wound	Pregnancy	Paroxysmal cold hemoglobinuria	
Raynaud's disease	Rheumatic Fever	Seizures	Shortness of breath	Skin cancer	Stomach problems
Stroke	Thyroid disorder	Cancer: (Please list type) _____			

Please complete this section if you are interested in:

INJECTABLES / LASERS / SKIN CARE

1) What is your skin type: ☐Dry ☐Oily ☐Normal ☐Combination

2) Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation? Please list: _____

_____

3) Have you ever had any of the following Injectables or implants: (please circle)

Botox	Dysport	Restylane	Perlane	Sculptra	Voluma
Collagen	Lipo Dissolve	Silicone	Hylaform	Radiesss	Juvederm

If so, when was it done _____ *What area(s)* _____

4) Do you have any of the following chronic skin disorders? (please circle)

Psoriasis	Dermatitis	Eczema	Keloid Scarring	Cold Sores
Sun Blisters	Fever Blisters	Herpes Simplex/Blisters		

5) Have you ever undergone any of the following treatments? (please circle)

Microdermabrasion Acid Peel Cosmetic Surgery Accutane

6) Are you currently removing hair by any of the following methods? (please circle)

Laser Hair Removal Waxing Tweezing Nair type products Electrolysis

If so, when was last treatment done? _____ *What area(s)?* _____

Please complete this section if you are interested in:

SMARTLIPO / COOLSCULPTING/ CELLULAZE

Age: _____ Current Weight: _____lbs Height: _____ Is your general health good? ☐ Yes ☐ No

Name of family physician _____ Date of last physical _____

1) What attracted you most to learning about Smartlipo, Coolsculpting, or Cellulaze? _____

_____

2) What problem area(s) are you considering having treated? ***(Please circle area or areas)***

Abdomen	Inner Thighs	Arms	Neck
Flanks (Muffin Top)	Outer Thighs	Upper Back (Bra Area)	Male Chest
Other_____			

To the best of my knowledge, the information provided above is true and accurate.

Patient Signature _____ ***Date*** _____

Provider Signature _____ ***Date*** _____

Since 2008, physicians from all over attend Smartlipo courses at Advanced Aesthetics from Dr. Kevin Johnson. Check here if you would like more information about becoming a training model: _____

Please complete this section if you are interested in:

FEMININE REJUVENATION TREATMENT

Health History

Name: _____ Age: _____ Date: _____

1) Are you concerned about the appearance of your external genitalia / labia?
2) Does this concern affect your quality of life / confidence? ☐ Yes ☐ No
3) Have you delivered a child vaginally? ☐ Yes ☐ No
4) Do you feel your vagina is looser than it used to be? ☐ Yes ☐ No
5) Does this looseness impact your sexual satisfaction / sexual confidence? ☐ Yes ☐ No
6) Do you have urinary frequency, incontinence, or stress incontinence? ☐ Yes ☐ No

7) Have you started, are you going through menopause, or are you post menopause?
☐ Started ☐ In Menopause ☐ Post Menopause

8) As a result of menopause, do you suffer from:

Vaginal dryness	☐ Yes	☐ No	☐ Sometimes
Burning or itching	☐ Yes	☐ No	☐ Sometimes
Painful intercourse	☐ Yes	☐ No	☐ Sometimes

Gynecological History:

Last PAP _____(mm/dd/yy) PAP results: ☐ Normal ☐ Abnormal Performed by whom?_____

History of abnormal PAP smears? ☐ No ☐ Yes If yes, nature of diagnosis, treatment, and follow up:

_____

Last menstrual period _____(mm/dd/yy) OR ☐ Menopausal

Please Check if Applies to You:

☐ Vaginal or Pelvic area surgery within the last 12 months
☐ Active malignancy or cancer treatment within the last five years
☐ History of Accutane use in the previous 6 months
☐ History of oral corticosteroid use in previous 6 months
☐ Uterine prolapse, cystocele or rectocele
☐ Diseases which may be stimulated by light
☐ Pelvic lymph node dissection or poor lower lymphatic drainage
☐ Use of anticoagulants or history of bleeding disorders
☐ History of skin disorders, keloids, abnormal wound healing
☐ History of oral or genital herpes
☐ Urinary tract infection
☐ Pelvic infection
☐ Pregnancy and nursing
☐ Melanoma History
☐ Tattoo in the treatment area
☐ Dysplastic nevi in the treatment zone
☐ Active electrical implant in any region of the body
☐ Pelvic mesh surgery
☐ Significant illness such as diabetes, cardiac disease, autoimmune disease
☐ Diseases of the immune system such as HIV, AIDS or immunosuppressive med
☐ History of epidermal or dermal disorders involving collagen or microvasculature
☐ Any active condition in the treatment area, such as open lacerations, abrasions or lesions, psoriasis, eczema, or rashes
☐ Excessively tanned skin in the treatment area from sun, sun-beds or tanning creams

Comments / questions: _____

_____

To the best of my knowledge, the information provided above is true and accurate.

Patient's Signature _____ ***Date*** _____

Provider's Signature _____ ***Date*** _____

Please complete this section if you are interested in:

VASCULAR HEALTH INFORMATION

Health History

Name: _____ Age: _____ Date: _____

Chief Complaint: _____

Where is the pain/problem? _____

When did you first notice varicose veins? _____

Have you had SURGERY for your veins? ☐ Yes ☐ No SCLEROTHERAPY? ☐ Yes ☐ No LASER treatment? ☐ Yes ☐ No

*If yes to any of the above, please list **physician or facility and date(s) of treatment**:* _____

_____

_____

Have you worn compression stockings? ☐ Yes ☐ No If yes, when did you start: _____ end: _____

Does anyone in your family have varicose veins? ☐ Yes ☐ No If yes, whom? _____

Do you experience any of the following:

a) Pain in your legs ☐ Yes ☐ No
b) Aches in your legs ☐ Yes ☐ No
c) Leg cramps ☐ Yes ☐ No
d) Restless legs ☐ Yes ☐ No
e) A heavy / full sensation in your legs ☐ Yes ☐ No
f) Do you have or have you had leg ulcers ☐ Yes ☐ No
g) Do you take medications for your leg pain ☐ Yes ☐ No
If so, what type: Tylenol Motrin Aspirin Other: _____
h) Do you elevate your legs for pain / swelling relief ☐ Yes ☐ No
i) Have you ever had a DVT or blood clot in your leg ☐ Yes ☐ No
j) Have you ever had thrombophlebitis or swelling of the veins ☐ Yes ☐ No
k) Have you had bleeding or bruising from your veins ☐ Yes ☐ No

To the best of my knowledge, the information provided above is true and accurate.

Patient's Signature _____ ***Date*** _____

Provider's Signature _____ ***Date*** _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

With my consent, Advanced Aesthetics may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Advanced Aesthetics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Advanced Aesthetics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Advanced Aesthetics' Privacy Officer, at 608 Northwest Boulevard, Suite 301; Coeur d'Alene, ID 83814.

Patients find it convenient to send and/or receive communications from our office by traditional, unsecured, text and/or email. Please confirm below you would like to communication through these channels, even though they may no longer be protected by HIPAA. Your choice either way will have no impact on our decision to treat you:

I give authorization for:

- Advanced Aesthetics to send me **EMAILS** containing information, appointment confirmations, patient paperwork, etc., that is requested by patient and/or practice to assist the practice in carrying out TPO. *Pt's initials* _____
- Advanced Aesthetics to send me unencrypted **TEXT** appointment reminders for appointment confirmations. *Pt's initials* _____
- Advanced Aesthetics may **PHONE** my home or other designated location and leave a message on **VOICE MAIL** or in person in reference to any items that assist the practice in carrying out TPO. *Pt's initials* _____
- I consent to receive **MAILINGS** to my mailing address for items such as patient information, statements, or any forms that are requested by patient and/or practice. *Pt's initials* _____

I have the right to request that Advanced Aesthetics restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Advanced Aesthetics' use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Advanced Aesthetics may decline to provide treatment to me.

My signature below indicates that I have read and understand these policies.

_____ _____ _____

Patient's Signature | Please Print Your Name | Date

_____ _____

Provider's signature | Date

ADVANCED AESTHETICS' NO SHOW, CANCELLATION, AND REFUND POLICY

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointments with Advanced Aesthetics are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments. Please review our NO SHOW AND CANCELLATION POLICY below.

1) In an effort to decrease unnecessary costs and to contain our fees, we maintain a **No Show/Cancellation Policy** for all our patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or unable to be kept must be cancelled **more than 24 hours** in advance. Cancellations must be made between 8 a.m. and 5 p.m. on workdays at least one full business day before the scheduled appointment. Cancellations must be done over the telephone by speaking directly to one of our scheduling professionals. *Pt's initials* _____

2) In the event an appointment is missed or cancelled with less than 24 hours' notice or no notice, a deposit for future services may be required. If more than 2 no-show or same day cancellations occur, we reserve the right to consider terminate the patient-doctor relationship. This policy is in effect for all appointments in both offices, including clinical and cosmetic appointments. *Pt's initials* _____

3) Advanced Aesthetics has a **NO REFUND** policy for purchased services, treatments, and/or products. Scheduling surgical procedures requires half down of the total charges. Remaining balance is due 2 weeks prior to procedural date. A procedure may be rescheduled ONCE without forfeiting deposit fee and being removed from schedule. *Pt's initials* _____

Finally, we advise you to review this agreement with the counsel of your choosing and by signing this agreement you acknowledge that you have had an opportunity to review this agreement with counsel of your choice if you desire to do so. This agreement shall be valid and enforceable for five years from Advanced Aesthetics last date of service to you. Advanced Aesthetics reserves the right to modify any policies without notice.

My signature below indicates that I have read and understand these policies.

_____ _____

Patient or Responsible Party Signature | Date

Provider's Initials _____