



522 W Riverside, Suite 202;
Spokane, WA 99201
(855) DR-KEVIN (375-3846)

608 Northwest Blvd. Suite 301;
Coeur d' Alene. ID 83815
(208) 676-8346

Patient Name _____ DOB _____ Today's date _____

Address _____ City _____ State _____ Zip _____

Home (_____) _____ Cell (_____) _____ Work (_____) _____

Primary contact number? (H) (C) (W) Sex: M ___ F ___ Marital Status: S ___ M ___ W ___ D ___

Occupation _____ Employer _____

Emergency Contact _____ Relation _____ Phone (_____) _____

Email Address: _____

Would you like to receive future monthly emails for promotional events, discounts, and specials from Advanced Aesthetics?
(Y) ___ (N) ___ **Please Note: Your email address is used strictly for our communication with you and will not be given out.**

How did you hear about us? Website/Internet ___ Newspaper ___ Billboard ___ TV Commercial ___

Radio ___ Friend ___ (name) _____ Other (please specify) _____

HEALTH INFORMATION

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

- | | | | |
|-------------------------------|---------------------------------|--------------------------------|-----------------|
| Black or Whiteheads | Brown spots (hyperpigmentation) | Cellulite | Clogged pores |
| Dry patches | Enlarged pores | Excessive oiliness | Scarring |
| Skin laxity | Spider veins | Stretch marks | Upper lip lines |
| Unwanted body fat | Unwanted hair | Uneven skin tone | Varicose Veins |
| Visible exposed blood vessels | | White spots (hypopigmentation) | Wrinkles |

Other: _____

Are you pregnant or trying to become pregnant? _____ Do you use oral contraceptives? _____

Are you allergic to any cosmetic ingredients or foods? (Y) ___ (N) ___ If yes, please list:

Do you have any neuromuscular or autoimmune diseases? (Y) ___ (N) ___ List: _____

Do you have allergies to latex? (Y) ___ (N) ___ Do you have a fear of needles? (Y) ___ (N) ___

Do you smoke? (Y) ___ (N) ___ If yes, how many per day _____ How many years _____

Do you drink alcohol? (Y) ___ (N) ___ If yes, how much _____ How often _____

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

Do you have any allergies to medications? (Y) ___ (N)___ If yes, please specify and state type of reactions:

Do you take Aspirin, Advil, Motrin, Ibuprofen, or anti-inflammatory meds more than once a week? (Y) ___ (N) ___ If yes, please explain: _____

Do you take oral anti-coagulant (blood thinning) medication? (Y) ___ (N) ___ Specify: _____

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

Please list all surgeries or hospitalizations with dates: _____

Have you 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	Heart attack	Heart valve disease	Heart failure
Heart valve replacement	Hepatitis	High blood pressure	HIV	Hormonal problems
Irregular heart beat	Intestinal problems	Impaired circulation	Impaired skin sensation	Keloids (scars)
Kidney disease	Liver disease	Lung disease	Multiple Sclerosis	Muscular dystrophy
MVP	Migraines	Open Infected wound	Paroxysmal cold hemoglobinuria	Shortness of breath
Pregnancy	Raynaud's disease	Rheumatic fever	Seizures	
Skin cancer	Stomach problems	Stroke	Thyroid disorder	

Cancer: (Please list type) _____

**Please complete this section if you are interested in:
SMARTLIPO / COOLSCULPTING/ CELLULAZE**

Age: _____ Current Weight: _____ lbs Height: _____ **OFFICE USE – BMI:** _____

Is your general health good? Yes ___ No ___ Date of last physical _____

Name of family physician _____

What attracted you most to learning about Smartlipo / Coolsculpting or Cellulaze? _____

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

PATIENT'S SIGNATURE:

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

Patient Signature _____ Date _____

Provider Signature _____ Date _____

**Please complete this section if you are interested in:
INJECTIBLES / LASERS / SKIN CARE**

What is your skin type: Dry _____ Oily _____ Normal _____ Combination _____

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

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

Botox Juvederm Radiesss Perlane Silicone Collagen Hylaform
Lipo Dissolve Other: _____

If so, when was it done _____ What area _____

Please check the products you currently use and list the BRAND NAMES (if possible) of Cosmetic Products:

Cleanser _____	Soap _____
Moisturizer _____	Night Cream _____
Toner _____	Eye Cream _____
Mask _____	Glycolic Wash/Cleanser _____
Astringent _____	Scrub _____
Salicylic Wash/Cleanser _____	Sunscreen _____
Vitamin A Cream _____	Vitamin C Creams _____
Alpha or Beta Hydroxy Cream _____	

Do you have any of the following chronic skin disorders?

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

Have you ever undergone any of the following treatments?

Microdermabrasion _____ Acid Peel _____ Cosmetic Surgery _____ Accutane _____

Are you currently removing hair by any of the following methods?

Laser Hair Removal _____ Waxing _____ Tweezing _____ Nair type products _____ Electrolysis _____

If so, when was it done? _____ What area? _____

What type of laser equipment was used? _____

PATIENT'S SIGNATURE:

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

Patient Signature _____ Date _____

Provider Signature _____ Date _____

HIPA - PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 anytime. 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.

With my consent, **Advanced Aesthetics** may call 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. I also consent in the mailings to my mailing address to receive items such as appointment reminder cards and/or patient statements or any forms that are requested by patient and/or practice.

With my consent, **Advanced Aesthetics** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. 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.

Patient's Signature of Patient

Date

Please Print Your Name

Photograph Release

I, _____ do release my medical photographs to Advanced Aesthetics and/or CDA Surgical & Vein Center for medical, educational and training use. I give permission to Advanced Aesthetics to use my photographs for said purposes and to reveal pertinent limited information about my medical condition in an effort to give a clinical presentation regarding my treatment and outcomes.

In the usage of said photographs and limited information, Advanced Aesthetics and /or CDA Surgical and Vein Center will not identify me by name or any other method that would allow for identification of me in association with my photographs and/or medical history.

I may request copies of my photographs, but acknowledge that they are the property of Advance Aesthetics and / or CDA Surgical and Vein Center and I may not use them for any purposes other than for my own personal medical records.

Patient's signature

Date

Witness' signature

Date