CONSULTATION & MEDICAL HISTORY FOR COSMETIC TREATMENTS

THANK YOU FOR CHOOSING RADIANT SKIN CARE CENTER FOR YOUR SKIN CARE NEEDS. PLEASE FILL OUT THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE. ALL INFORMATION WILL BE KEPT IN THE STRICTEST OF CONFIDENCE. PLEASE PRINT AND ANSWER ALL QUESTIONS.

Last Name:______________________________First Name:_________________________________

Address:____________________________________City_____________State____Zip:_________

Phone: Home:__________________Cell:_________________Work:_______________________

Best number to confirm an appointment? (circle one) H C W May we leave a message? Y/N

Do you want to find about what specials we are having monthly? Please include your email.

Date of Birth:_______________Age:________Email:______________________________________

How did you hear about us? ____

Family Doctor:_____________________________Phone:____________________________________

Pharmacy:__________________________________Phone:___________________________________

Emergency Contact:_________________________Phone:____________________________________

Reason(s) for consultation.. circle what bothers you the most: lines/wrinkles, texture, dryness, dull appearance, blotchiness/uneven skin tones, freckles/brown(sun) spots, hair, acne, blackheads, scars, precancers, redness/blood vessels, frown lines, folds around nose/mouth, neck, chest, hands, other____

Previous Cosmetic Treatments..circle: facials, microdermabrasion, chemical peels, laser, Botox, Juvederm-Restylane or other fillers, intense pulsed light, photodynamic therapy, hair removal, resurfacing, blepharoplasty, brow lift, face lift, other_____________________

Satisfaction, side effects and other results from previous treatments:

____

____

Which of the following best describes your skin type? (circle one)

I-Always Burns, Never Tans
II- Always Burns, Sometime Tans
III-Sometimes Burns, Always Tans
IV-Rarely Burns, Always Tans
V-Brown, Moderate Pigmented Skin
VI-Black Skin

Nationality
Father's_____________________
Mother's____________________

Current Skin Care Regimen/Products used:

Sunscreen Brand___________SPF________Daily use? Y/N Sunscreen only when outside? Y/N

Cleanser, moisturizer, anti-aging creams, Retin-A, Vitamin C, Glycolic Acid, firming creams, lighteners, fade creams, other____

Am Regimen____

Pm Regimen____

Do you have ANY current or chronic medical illnesses that we should know about? Y/N

Please List____

Do you have ANY allergies to medications, foods, latex, or other substances? Y/N

Please List____

Do you take/use ANY medications, both prescription and non-prescription, herbal or natural supplements, or topical on a regular or daily basis? Y/N

Please List____

Y/N Do you have a history of "cold sores", Herpes I or II?

Y/N Do you have a history of diabetes, hypertension, cholesterol, or problems with wound healing?

Y/N Do you have any sensitivity to heat, i.e. heat rash or hives?

Y/N Do you have a history of keloid or hypertrophic scarring or abnormal scarring?

Y/N Do you take St. John's Wort or any anticoagulants? (Plavix, Aggrenox, Aspirin)

Y/N Do you have any permanent make-up, implants or tattoos?________________

Y/N Do you have any open lesions in the area to be treated?

Y/N Have you ever taken Accutane?

Y/N Have you had or are you undergoing any treatments for cancer? Type________________

Y/N Have you used any exfoliating creams or products (Retin *A, Differin, Glycolic acid, Alpha-Hydroxy acid products*) in the past 2 weeks?

Y/N Have you had mechanical epilation (*plucking, tweezing, electrolysis, or sugaring*) less than 4 weeks ago?

Y/N Have you had any unprotected sun exposure, used self tanning creams or tanning beds in the last 4-6 weeks to the area to be treated?

Y/N Are you sensitive to sunscreens or anti-aging creams?

For WOMEN:

Y/N Are you or could you be pregnant?

Y/N Are your periods regular?

PATIENT CONSENT AND AUTHORIZATION TO TREAT

WITH ALL OF THE OPTIONS IN SKIN CARE TODAY, WE ARE PLEASED THAT YOU HAVE SELECTED THE SERVICES OF THE RADIANT SKIN CARE CENTER. WE ARE CERTAIN YOU WILL FIND THAT OUR STANDARDS AND PERSONALIZED PATIENT CARE RANK AMONG THE BEST IN THE INDUSTRY. DR. RIOUX AND HIS NURSE (AND WIFE) ELIZABETH HAVE BEEN EXTENSIVELY TRAINED IN AESTHETIC MEDICINE. OUR STAFF IS MORE THAN HAPPY TO ANSWER ANY QUESTIONS THAT YOU MAY HAVE.

IT IS TRULY OUR PLEASURE TO WELCOME YOU TO OUR PRACTICE OF SKIN CARE--"IT'S ALL WE DO"!

NOTICE OF CONFIDENTIALITY

I UNDERSTAND THAT MY TREATMENT RECORDS WILL BE RETAINED FOR A FULL THREE YEARS AFTER TREATMENTS CEASE. DURING THIS TIME, ALL STAFF AT THE RADIANT SKIN CARE CENTER, INCLUDING THE PHYSICIAN(S), NURSE(S), AND CLERICAL STAFF WILL HAVE COMPLETE ACCESS TO MY RECORDS, SOLELY FOR TREATMENT PURPOSES. NO THIRD PARTY SHALL EVER RECEIVE COPIES OF MY RECORDS WITHOUT MY SPECIFIC WRITTEN CONSENT.

MEDICAL HISTORY DISCLOSURE

DR. RIOUX AND THE STAFF OF RADIANT SKIN CARE CENTER WANT TO PROVIDE ME WITH THE UTMOST LEVEL OF CARE. THUS, I AM AWARE OF THE IMPORTANCE OF DISCLOSING MY COMPLETE PERSONAL MEDICAL HISTORY. I WILL NOTIFY DR. RIOUX AND THE STAFF OF ANY CHANGES IN MY HEALTHCARE AS THEY OCCUR DURING MY TREATMENT(S) . ADDITIONALLY, I WILL ALSO DISCLOSE ALL MEDICATIONS THAT I CURRENTLY TAKE INCLUDING PRESCRIPTION AND OVER THE COUNTER DRUGS, HERBS, SUPPLEMENTS AND VITAMINS. I UNDERSTAND THAT MY FAILURE TO DO SO MAY RESULT IN AN INCREASE IN THE LIKELIHOOD OF SIDE EFFECTS OR COMPLICATIONS OF TREATMENT(S) I RECEIVE.

GUARANTEES

I UNDERSTAND THAT THE TREATMENT(S) I MAY REQUEST TO BE DONE ARE VOLUNTARY ON MY PART. THERE ARE NO GUARANTEES THAT THE TREATMENT(S) WILL WORK AS I HAD EXPECTED. EVERY EFFORT WILL BE DONE, HOWEVER BY DR. RIOUX AND THE STAFF OF THE RADIANT SKIN

CARE CENTER, TO ACHIEVE THE BEST POSSIBLE OUTCOME FOR ME. INDIVIDUAL TREATMENTS AND WHAT TO EXPECT WILL BE DISCUSSED WITH ME FULLY AND MY CONSENT WILL BE OBTAINED PRIOR THE BEGINNING OF ANY TREATMENT(S). I UNDERSTAND THAT SOME TREATMENTS ARE IN PACKAGES TO ACHIEVE MAXIMUM RESULTS. RESULTS MAY VARY ACCORDING TO THE FOLLOWING FACTORS: SKIN TYPE, AREA(S) OF BODY BEING TREATED, NATURAL HAIR COLOR, PRE AND POST TREATMENT COMPLIANCE, FOLLOW-UP CARE AND TANNING BY SUN EXPOSURE OR SELF-TANNING PRODUCTS.

I UNDERSTAND THAT THIS SIGNED CONSENT FORM SHALL REMAIN EFFECTIVE THROUGHOUT MY CARE AT RADIANT SKIN CARE CENTER.

WE TRULY VALUE AND RESPECT YOUR TIME AND WILL MAKE EVERY EFFORT TO SEE YOU AT YOUR APPOINTED TIME. WE WOULD APPRECIATE AT LEAST 24 HOURS NOTICE IF YOU CAN NOT MAKE YOUR SCHEDULED APPOINTMENT. IF FOR SOME UNFORESEEN REASON YOU MISS AN APPOINTMENT WITHOUT NOTIFYING OUR OFFICE A CREDIT CARD DEPOSIT OF $150 WILL BE REQUIRED TO SECURE YOUR NEXT APPOINTMENT. THIS AMOUNT MAY BE APPLIED TO YOUR UPCOMING SERVICES OR PRODUCTS, BUT NOT REFUNDED, IN ANY PART, FOR ANY SERVICES OR PRODUCTS COSTING LESS THEN $150.00.

MOREOVER, YOUR INITIAL CONSULTATION IS AT NO CHARGE. HOWEVER, IF YOUR CONSULTATION INVOLVES ANYTHING OTHER THEN PRODUCT/SERVICE RECOMMENDATIONS; (IE. PRESCRIPTIONS, TREATMENTS, OR PRODUCTS) THEN AN OFFICE VISIT CHARGE WILL BE ASSESSED.

I FULLY UNDERSTAND AND ACCEPT ALL OF THE ABOVE INFORMATION.

PRINTED NAME:____

SIGNATURE:____DATE:____________________