genesis MED SPA by Joseph W. Sharlow, MD, FACS

CLIENT INFORMATION

Date: _____ Birth date: ____/____/____ Sex: M F

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____ Work: _____

Preferred Contact Number: _____Home ____Cell _____Work

Email: _____ Information/Specials by Email: Y N

Emergency Contact: _____ Phone: _____

Relationship: _____

Please put a check mark next to the procedure(s) about which you would like to receive more information on (check all that apply):

_____ Skin Rejuvenation Advance	_____ Spider Veins/Leg Veins	_____ Botox
_____ Sun Damage/Brown Spots	_____ Tissue Fillers	_____ Cellulaze
_____ Sublative Rejuvenation	_____ Laser Hair Removal	_____ Acne Treatment
_____ SculpSure	_____ Neck Contouring	_____ Smartlipo

Other _____

Known Allergies: _____

Are you Pregnant? _____ Y _____ N

Please list any medications that you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____

Client Signature Name & Relationship, *if different from Client*

Rev 03/16

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HIPPA PRIVACY RULE

A federal regulation, known as the "**HIPPA PRIVACY RULE,**" requires that we provide you a detailed notice, in writing, of our privacy practices, upon request. It also requires us to address any special needs you may have and to assure you that your client information is kept confidential.

May we call to remind you of your appointment? _____ Yes _____ No

May we leave a message on your answering machine? _____ Yes _____ No

May we call you at work? Work #: _____ _____ Yes _____ No

Other than yourself, do you authorize our office to discuss information with any other family member(s) and/or designated contact? _____ Yes _____ No

If so, who do you authorize?

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

Consent for Purpose of Treatment, Payment and Services

I, _____, consent to the use or disclosure of my protected health information for the purposes of providing treatment to me, obtaining payment for my treatment or to conduct healthcare operations of Genesis Med Spa. I have been advised that should I request a copy of the Office's Notice of Privacy Practices, Genesis Med Spa will provide one to me. I have been given the right to review such Notice of Privacy prior to signing this consent.

_____ _____

Client Name (Please Print) Client Signature

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Medical History

Name: _____ Birth Date: _____ Age: _____

Height:____ft_____in Weight: _____ lbs

Are you currently pregnant: _____

Please list any surgical procedures or hospitalization.

Year	Reason for hospitalization or surgical procedure.

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

_____Pacemaker/Defibrillator
_____Current or history of skin cancer/ other cancer
_____History of bleeding disorders
_____High Blood Pressure
_____Impaired immune System
_____Skin Disorders (e.g. keloids, abnormal wound healing)
_____Diseases stimulated by light (e.g. Lupus, Porphyria, Epilepsy, Seizure)
_____Use of medication / herbs inducing photosensitivity
_____Blood Vessel Disease (Thrombosis "blockage" phlebitis)
_____Injections/fillers
_____Metal Implants
_____High Blood Cholesterol or Triglycerises
_____Back Problems
_____Active skin Infection (e.g. psoriasis, eczema)
_____ Tattoo or permanent makeup
_____Arthritis
_____Diseases stimulated by heat (e.g. Herpes, Simplex)
_____Impaired Immune system
_____ Facial laser resurfacing / deep chemical peeling - last 3 months.
_____Lung Disease
_____Endocrine disorders (e.g. diabetes)
_____Other _____

Patient Signature **Date**