AESTHETIC AND LASER INTAKE

PATIENT (Legal Last Name):_____(Legal First Name):_____(MI):_____

Birthdate:_____AGE:_____Sex:_____Marital Status:_____

Street Address:_____City:_____State:_____Zip:_____

Hm Phone:_____(Msg Y / N) Work:_____ (Msg Y/ N) Cell:_____(Msg Y / N)

Preferred Method of appointment confirmation (circle): Text Message Email Telephone call

BE ST PHONE NUMBER (please circle): HOME WORK CELL OTHER_____

E-Mail Address:_____(Used for appointment confirmations & Monthly Specials)

Employer:_____ Occupation:_____

PERSON RESPONSIBLE FOR PAYMENT (if different from above)

NAME (Legal Last Name):_____(Legal First Name):_____(MI):_____

Birthdate:_____AGE:_____Sex:_____Marital Status:_____

Street Address:_____City:_____State:_____Zip:_____

Hm Phone:_____(Msg Y / N) Work:_____ (Msg Y/ N) Cell:_____(Msg Y / N)

Employer:_____Occupation:_____RELATIONSHIP TO PATIENT_____

NOTIFY IN CASE OF EMERGENCY

NAME:_____ RELATIONSHIP:_____

Hm Phone:_____ Work:_____ Cell:_____

HOW WERE YOU REFERRED TO OUR OFFICE (we like to thank our referrals, please identify all that apply!)

INTERNET or SOCIAL MEDIA: Google Main Website YELP Facebook Other?_____

NEWSPAPER / MAGAZINE: Women's Edition Boulder Lifestyle Daily Camera Broadlands Legacy

REFERRING PHYSICIAN: _____

FRIEND/RELATIVE: _____ OTHER:_____

PLEASE READ AND SIGN THE FOLLOWING

I understand that AURA and Dr. Roesner will not bill insurance for our standard surgical procedures or aesthetic treatment services. Payment is due in full prior to services rendered (please see financial policy). If my medical insurance needs to be billed due to medical emergency while I am under the care of AURA / Dr. Roesner, I then authorize my insurance benefits to be paid directly to my provider. I also realize I am responsible to pay non-covered services and/or the balance not paid by insurance. I authorize the release of pertinent medical information to my insurance carrier.

PATIENT SIGNATURE:_____ DATE:_____

Parent or Legal Guardian:_____ DATE:_____

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Best Number to reach you ( )_____ (Cell / Work / Home Other)
Can we leave a message at these numbers? Yes No

Injectable Clients:
Would you Like to receive a complimentary skin care consultation with VISIA computerized skin analysis ($50 value)? _____Yes! _____
No Thanks!

This information below is necessary for the evaluation of your procedure.

Please complete the following:

1. Any allergies to medications, cosmetics ingredients or foods? Yes / No
   If yes, list: _____
2. Please list current prescription, non-prescription or herbal medication you take_____
3. Do you take any food supplements? Yes / No
   If yes, list: _____
4. Do you take oral anti-coagulant (blood thinning) medication? Yes / No
   If yes, list:_____
5. Do you smoke?_____How much?_____How Long?_____
6. Do you drink alcohol?_____ How much?_____ Frequency?_____
7. Do you spend a lot of time outdoors or use a tanning bed? Yes NO
8. Do you have any tattoos or permanent make-up? Yes / No
   If yes, where?_____
9. Do you use hormone replacement therapy?_____
10. Are you currently using medical grade skin care line(s)? _____
    _____

For Women: Are you pregnant or trying to become pregnant? Yes / No
Do you use oral contraceptives? Yes / No

Do you have any of the following chronic skin disorders? (circle all that apply)

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Psoriasis Dermatitis Eczema Keloid Scarring Fever Blisters Cold Sores Herpes Simplex

Other:_____

Please answer the following questions on a scale of 1-5 by <u>circling</u> the appropriate number:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles:

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my age spots/discoloration:

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

AREAS OF INTEREST & CONCERN (check all that apply)

☐ Skin Analysis	☐ Acne	☐ Scarring
☐ Skin Care Product	☐ Pimples	☐ Excessive Dryness / Dry Patches
☐ Facial Fine Lines	☐ Blackheads / Whiteheads	☐ Body Contouring or Fat Transfer
☐ Face or Neck Wrinkles	☐ Enlarged Pores	☐ Loss of Facial Volume/Fullness
☐ Loose or Sagging Skin	☐ Clogged Pores	☐ Toxin free alternative to Botox
☐ Brown Spots (Hyperpigmentation)	☐ Excessive Oiliness	☐ Contour of Chest or Stomach
☐ White spots (Hypopigmentation)	☐ Hard Bumps Under the Skin	☐ Thin Lips / Upper Lip Lines
☐ Sun Damage	☐ Visible Blood Vessels/Veins	☐ *<u>other:</u>*
☐ Skin Texture	☐ Unwanted Hair	
☐ Uneven Skin Tone	☐ Redness	

HEALTH ISSUES, PAST OR PRESENT (check all that apply)

☐ Vasovagal Syncope	☐ Hormonal Problems	☐ Thyroid Disease
☐ Heart Problems	☐ Diabetes	☐ Cystic Acne
☐ High Blood Pressure	☐ Seizures	☐ Hepatitis
☐ Palpitations	☐ Liver Disease	☐ Cancer _____
☐ Angina	☐ Diabetes	☐ Neurologic Disorders
☐ Congestive Heart Failure	☐ Hormonal Problems	☐ *<u>other:</u>*
☐ Collagen Disorders	☐ Mental Illness	☐
☐ Lupus	☐ Bipolar Disorder	☐
☐ Sarcoid	☐ Depression	☐

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☐ Schleroderma	☐ Skin Cancer	☐

FITZPATRICK SKIN TYPE *(Please Circle)*

Score	0	1	2	3	4
What color are your eyes?	Light Blue, Gray, Green	Blue, Gray, or Green	Blue	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut / Dark Blonde	Dark Brown	Black
What is the color of your skin (non-exposed areas)?	Reddish	Very Pale	Pale with beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None
← TOTAL Score for genetic disposition					
Score	**0**	**1**	**2**	**3**	**4**
What happens when you stay too long in the sun?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you turn dark brown within several hours of exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
← TOTAL Score for reaction to sun exposure					
Score	**0**	**1**	**2**	**3**	**4**
When did you last expose your body to sun (or tanning cream/artificial sunlamp?)	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always
← TOTAL Score for tanning habits					

Summary

	← Total Score for genetic disposition
	← Total Score for reaction to sun exposure
	← Total Score for tanning habits
	← Skin Type Score

YOUR FITZPATRICK SKIN TYPE

SKIN TYPE SCORE	0-7	8-16	17-25	25-30	OVER 30
FITZPATRICK SKIN TYPE	I	II	III	IV	V

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SIGNATURE______ DATE_____

The use of photographs is essential to the planning and evaluation of aesthetic plastic surgery and many non-surgical or laser procedures. Your procedure will be photographically documented before, possibly during, and after the procedure. These photographs are a permanent part of your medical record, and will never be shown to anyone else without your consent.

Signature_____ Date _____

Staff Signature _____ Date _____

Notice of Privacy Policy

Certain government regulations, known as Health Insurance Portability and Accountability Act of 1996 (HIPAA), require medical providers to explain their privacy and security policy so that information obtained by us about you is used appropriately.

***How we may use and disclose Protected Health Information (PHI) about you:**

- Treatment, management and coordination of your health care needs.
- Payment of any and all medical claims.
- Normal operation of our business, such as quality review and training of our staff.
- Communication from our office, such as to contact you to verify appointments, or to leave a message on voicemail with test results or to answer questions.
- As required by law, to include but not limited to Public Health activities, abuse issues and legal proceedings.

***Your rights regarding PHI about you:**

- You have the right to request restrictions.
- You have the right to receive confidential communications.
- You have the right to inspect and copy PHI about you (a charge may apply for copies received).
- You have the right to request that we amend your PHI.
- You have the right to receive an accounting of disclosures.
- You have the right to obtain a paper copy of our complete Notice of Privacy Practices.

Restrictions Requested:

_____

_____

_____

Signature: _____Date:_____

(To acknowledge receipt of this policy)

**This is not a complete listing of our Privacy Practices. Please ask to see our complete Notice of Privacy Practices.

***We reserve the right to make changes to this Notice and make such changes effective for all PHI we may already have about you. We will post any and all changes in a prominent location, and provide you a copy upon request.

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