Bloom Medical Aesthetics Patient Questionnaire

Name: _____ Age: _____ Date of Birth: _____/_____/_____

Gender: M / F Height: _____ Weight: _____ Race: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

E-mail: _____ How did you hear about us? : _____

Employer: _____ Occupation: _____

Marital Status: □Single □Married □Divorced □Widowed

In case of emergency, whom should we contact? _____ Relationship: _____

Phone number of emergency contact: _____

Primary Care Physician & Location: _____

Medical History

Have you ever had (please check all that apply):

□ Heart disease	□ Neuromuscular disease	□ Implanted electrical device	□ Delayed or abnormal wound healing
□ Hypertension	□ Migraines	□ Endocrine or hormone disorder (i.e., hypothyroidism or hyperthyroidism)	□ HIV or AIDS
□ Heart pacemaker or defibrillator	□ Eye conditions or change in vision	□ Diabetes	□ Hepatitis
□ Easy bleeding or bruising			□ Cancer

List any active medical problems you have:

_____

List any medications you currently take:

_____

List any medication/food allergies you have:

_____

Are you allergic to any metals? _____ Are you allergic to latex? _____ Are you currently pregnant or nursing? _____

Have you had any dental work, including cleanings, performed in the last two weeks? _____

Do you smoke tobacco/marijuana products or vape? _____ Do you drink alcohol? _____ Frequency? _____

Surgical History

List any operations you have had with dates:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Skin History

Have you ever had (please check all that apply):

□ Chronic skin conditions	□ Keloid or hypertrophic scar	□ Injection of collagen or other dermal filler
□ Skin cancer - site _____	□ Accutane use for acne	□ Recent waxing or plucking
□ Laser skin resurfacing	□ Botox® injection	□ Electrolysis or threading
□ Photosensitivity	□ Pigmentation disorder	□ Recent sunburn or tan (include tanning bed)
□ Herpes simplex or cold sores	□ Tetracycline use for acne	
□ Chemical peel	□ Liposuction/fat transfer	

Have you ever experienced negative reactions/adverse effects to any of the procedures selected above? _____

If yes, please explain: _____

What is your ethnic background? _____

When exposed to the sun, do you usually:

□ Always burn, never tan □ Burn easily, tan poorly □ Tan after initial burn

□ Burn minimally, tan easily □ Rarely burn, tan darkly easily □ Never burn, always tan darkly

What would you classify your skin-type as?

□Sensitive □Normal □Dry □Oily □Combination

Do you use sunscreen regularly? _____ Do you use artificial or "sunless" tanning products? _____

Do you use retinol? _____

List any skin care products you use:

_____ _____ _____

_____ _____ _____

What area is your concern? _____

What improvement/change do you hope to make? _____

Patient Signature: _____ Date: _____

Printed Name: _____

Parent or Guardian (if patient is under 18 years of age): _____

Reviewed by/discussed with Medical Director/NP: _____

Communication Preference Form

In our desire to respect your personal space and your privacy, please let us know how you would like to be contacted by our staff.

We typically confirm with our clients 24 - 48 hours prior to appointments. Please check one of the options below indicating your preference.

_____ I would like to be called on this phone number: _____

_____ I would like to be e-mailed at this address: _____

_____ I prefer not to receive a confirmation call or email, and I understand Bloom Medical Aesthetics has the right to charge me for no-show appointments.

In order to provide the best in customer care, we like to follow-up with our clients 1-2 days after your treatment. Please check one of the options below indicating your preference.

_____ I would like to be called on this phone number: _____

_____ I would like to be e-mailed at this address: _____

_____ I prefer not to be called or emailed after treatment.

I understand that without follow-up contact, it will be my responsibility to notify Bloom Medical Aesthetics if I have any concerns or complications after a treatment.

Approximately 3-4 times a year, we correspond by mail with our clients. These include such items as thank you notes, notices of special offers and events, educational newsletters and birthday greetings. Please check one of the options below.

_____ I am willing to receive mailings at the address I wrote on my intake form.

_____ I do not wish to receive mailings.

Approximately 2-3 times a month, we correspond by e-mail with our clients. These include such items as notices of special offers and events, educational newsletters and special greetings. Please check one of the options below for how you would like us to handle this with you.

_____ I am willing to receive e-mails at the address I wrote on my intake form.

_____ I do not wish to receive e-mails.

Patient Signature: _____ Date: _____

Printed Name: _____

Parent or Guardian (if Patient is under 18 years of age):

_____

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS/SLIDES/VIDEOTAPES

Medical aesthetics is a visually oriented specialty. As such, it is necessary that medical photographs be taken before, during and after an aesthetic procedure or treatment. Similar to other imaging techniques like x-rays or CT scans, this allows for proper planning before procedures and follow up evaluation afterward. Photographs are required only for the body part in question. This means that unless the planned treatment is on the face or head itself, the images typically do not include the face. Consent is required to take such images.

Additionally, patients may consent to release these medical photographs/slides, and videotapes for a stated purpose such as for use in instructional, educational, or promotional materials. These materials are very important to insure continued understanding of the treatments available to all patients. Please read carefully the information contained in both sections below and provide your consent where applicable.

A signature in section 1 is required to receive your care at Bloom Medical Aesthetics. A signature in section 2, while encouraged, is optional.

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Elizabeth Sheiner, Medical Director of Bloom Medical Aesthetics, and/or her associates or licensees to take preprocedural, procedural, and post-procedural photographs, slides, and/or videotapes. I consent to the use of these images for the purposes of pre-procedural planning and post-procedural evaluation by Elizabeth Sheiner, NP and/or the staff of Bloom Medical Aesthetics, and I understand that they shall be made a part of my medical record.

Patient Signature: _____ Date: _____

Printed Name: _____

Parent or Guardian (if patient is under 18 years of age): _____

Witness: _____

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Elizabeth Sheiner, Medical Director of Bloom Medical Aesthetics, and or her associates or licensees to use preprocedural, procedural, and post-procedural photographs, slides, and/or videotapes for professional medical or promotional purposes as deemed appropriate by them including but not limited to display of these images on electronic digital networks, scientific medical publications, lay publications, or during lectures to medical or lay groups for the purposes of informing the medical community or the general public about plastic surgery and skin rejuvenation procedures available at Bloom Medical Aesthetics. Neither I nor any member of my family will be identified by name at any time. Unless it is necessary to include it, my face will not appear in the images. I understand that in some instances the images may portray features which could make my identity recognizable. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and I hereby grant this consent as a voluntary contribution in the interest of medical education. This permission may be rescinded by me at any time to prohibit future use by direct written communication with Elizabeth Sheiner or Bloom Medical Aesthetics.

Patient Signature: _____ Date: _____

Printed Name: _____

Parent or Guardian (if patient is under 18 years of age): _____

Witness: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all records of your care generated and maintained by this medical spa.
We are required by law to: 1) make sure that medical information that identifies you is kept private; 2) make available to you this notice of our legal and privacy practices with respect to medical information about you; and 3) follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

• We may disclose medical information about you to doctors, nurses, or other personnel involved in taking care of you. We may also disclose medical information to people outside the medical group, such as family members, specialists or others who are involved in providing services that are part of your care.

• We may use or disclose medical information about you for operations. These may include use of information to evaluate the performance of our staff, effectiveness of programs, and ways to improve care and services we offer. These uses and disclosures are necessary to ensure that all of our patients receive quality care.

• We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or care.

• We may use or disclose medical information to tell you about or recommend possible treatment options or alternatives, and about health-related benefits, services, events and activities that may be of interest to you.

• We may disclose medical information about you to other healthcare providers in the event you need emergency care.

• We may disclose medical information about you as required by federal, state or local law.

• We may use or disclose medical information to a public health organization or federal organization when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

• We may disclose medical information about you in special situations such as for workers' compensation programs, as required by military command authorities or the Department of Veterans Affairs, in response to a court or administrative order, or for public health activities.

• Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. You may later revoke this permission in writing at any time.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

• You have the right to review and receive a copy of medical information that may be used to make decisions about your care. Usually this includes medical and billing records. You must submit a written request to review and copy your medical information. We may charge a fee for the costs of supplying a copy of the records.

• You have the right to ask us to amend medical information that you feel is incorrect or incomplete. Your request for an amendment must be submitted in writing and must provide a reason that supports your request. We may deny your request for amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information: 1) was not created by us; 2) is not part of the medical information kept by or for us; 3) is not part of the information which you are permitted to inspect and copy; or 4) is accurate and complete.

• You have the right to request an "accounting of disclosures." This is a list of disclosures we have made of medical information about you, with some exceptions. The exceptions are governed by federal health privacy law, and include: 1) routine disclosures for treatment, payment and operations conducted pursuant to your signed consent form; and 2) disclosures to you. You must submit a written request. The request must state a time period that may not be longer than six years and may not include dates before April 14, 2003, when current federal health privacy laws became effective.

• You have the right to request restrictions or limitations on the use or disclosure of medical information about you. You must submit a written request for restriction that specifies: 1) what information you want to limit; 2) whether you want to limit our use, disclosure, or both; and 3) to whom you want the limits to apply. We reserve the right to refuse your restriction if it conflicts with providing you quality healthcare or in an emergency situation.

• You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, such as only at work or by mail. You must submit a written request for confidential communications restrictions, specifying how or where you wish to be contacted. We will accommodate reasonable requests.

• You have the right to possess a copy of this Privacy Notice upon request. You may receive a paper copy of this notice, or you can also obtain a copy of this notice at our offices.

• You have the right to file a complaint if you believe your rights to privacy have been violated. All complaints must be submitted in writing. All complaints will be investigated. No personal issue will be raised for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We will post a copy of the current notice at our clinical site.

ACKNOWLEDGMENT OF RECEIPT

Notice of Privacy Practices provides information about how we may use and disclose your protected health information.

In addition to the copy we are providing you, copies of the current notice are available at our office.

I, _____ acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Print Name Relationship to Patient

WRITTEN ACKNOWLEDGMENT NOT OBTAINED

Please document your efforts to obtain acknowledgment and reason it was not obtained.

_____ Notice of Practices Given — Patient Unable to Sign

_____ Notice of Practices Given — Patient Declined to Sign

_____ Notice of Privacy Practices and Acknowledgment Mailed to Patient

_____ Other Reason Patient Did Not Sign _____

_____ _____

Signature of Representative Date

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