ASPIRE DERMATOLOGY
Dr. Jason Michaels
MAKE AN APPOINTMENT: 401.239.1800

COSMETIC PATIENT INFORMATION

Please Complete All Sections on All Pages

PREFERRED PHONE _____ OK to leave message: Yes ☐ No ☐

ALTERNATE PHONE _____ OK to leave message: Yes ☐ No ☐

PATIENT'S NAME (Last, First, MI) _____**SEX**_____ **BIRTH DATE**____/____/_____

PRIMARY ADDRESS (STREET) _____ **APT#**_____

CITY _____ **STATE** _____ **ZIP**_____

ALTERNATE ADDRESS (STREET) _____ **APT#**_____

CITY _____ **STATE** _____ **ZIP**_____

EMAIL ADDRESS_____

Would you like to receive emails from Aspire Dermatology for patient, practice, promotions and products information? *Yes* ☐ *No* ☐

HOW DID YOU HEAR ABOUT ASPIRE DERMATOLOGY? _____

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SKIN TYPE?

- ☐ **Very Oily Skin, large pores**
- ☐ **Oily Skin**
- ☐ **Dry Skin**
- ☐ **Sensitive Skin**
- ☐ **Combination Skin (Oily T-Zone, dry to normal cheeks)**

WHAT ARE YOUR AREAS OF CONCERN?

- ☐ **Frown lines between eyebrows**
- ☐ **Crease lines around nose & mouth**
- ☐ **Wrinkles around eyes/crow's feet**
- ☐ **Forehead lines/creases**
- ☐ **Skin Resurfacing**
- ☐ **Acne**
- ☐ **Freckles/Sun Spots**
- ☐ **Hyperpigmentation**
- ☐ **Facial Hair/Unwanted Hair**
- ☐ **Sagging Skin**
- ☐ **Double Chin**
- ☐ **Scars**
- ☐ **Vascular Lesions**
- ☐ **Other**_____

_____

_____

PHOTOGRAPH DISCLOSURE: **When it is appropriate and necessary, Aspire Dermatology staff and Providers may take clinical photographs during cosmetic consultations, pre and post treatments. These photographs are used to aid in tracking outcomes and professional education. Clinical photographs are considered a routine practice of the care and treatment of our patients and are covered within the general admission and consent to treat.**

RELEASE OF MEDICAL INFORMATION to other individuals if we are unable to reach you (HIPAA requirements)

I hereby authorize Aspire Dermatology and Jason Michaels, MD to communicate information regarding my procedure/results of my procedure/billing to/with:

Name_____**Relationship**_____**Phone:**_____

Certification of patient information

I have reviewed my patient demographic on this date and verify that all information reported to Jason Michaels, MD and Aspire Dermatology is correct. I hereby acknowledge that a copy of the Notice of Privacy Practices for Jason Michaels, MD/Aspire Dermatology has been made available to me. I have the right to obtain a paper copy upon request.

SIGNATURE:_____**DATE:**_____

PLEASE TURN THE PAGE OVER

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PATIENT NAME:_____ **DATE OF BIRTH:**_____/_____/_____

PAST MEDICAL HISTORY: (Please check all that apply)

- ☐ Currently Pregnant or Planning a Pregnancy
- ☐ Stroke
- ☐ Breastfeeding
- ☐ Bell's Palsy
- ☐ Immunosuppression: chemo/ radiation
- ☐ Multiple Sclerosis (MS)
- ☐ History of Severe Allergies
- ☐ Chronic Prednisone Use
- ☐ History of Anaphylaxis
- ☐ Heart Arrhythmias (slow/fast/irregular heartbeats)
- ☐ History of Accutane Use; if yes, completion date: _____
- ☐ HIV/AIDS
- ☐ Cardiovascular Disease
- ☐ Heart Attack
- ☐ History of Cold Sores
- ☐ Blood Thinners
- ☐ Allergy to Cow's Milk Protein
- ☐ Bleeding Disorder
- ☐ History of Poor Wound Healing
- ☐ Seizures
- ☐ History of hospitalization due to result of allergic reaction
- ☐ Neuromuscular Disorders or Muscle Weakness (ALS, Lou Gehrig's, Myasthenia Gravis or Lambert-Eaton Syndrome)
- ☐ Have had breathing problems (asthma or emphysema)
- ☐ Difficulty Swallowing
- ☐ History of Facial Surgery or Facial Implants
- ☐ Diabetes
- ☐ Tattoo or Permanent Makeup
- ☐ Keloid Scarring
- ☐ Breast Cancer: History of Radical Mastectomy
- ☐ History of Melanoma
- ☐ PCOS
- ☐ DLE/SLE

PREVIOUS COSMETIC PROCEDURES: (Please check all that apply)

- ☐ Botox
- ☐ Fillers (Juvederm/Radiesse/Restylane/Voluma)
- ☐ Kybella
- ☐ Microdermabrasion
- ☐ Chemical Peels
- ☐ Facials
- ☐ Extractions
- ☐ Tattoo Removal
- ☐ Laser Hair Removal
- ☐ Skin Resurfacing/Rejuvenation
- ☐ Skin Tightening

WHAT IS YOUR DAILY SKIN CARE REGIMEN? _____

_____

_____

_____

_____

DATE OF LAST SUN EXPOSURE? _____

PLEASE TURN THE PAGE OVER

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PATIENT NAME:_____ **DATE OF BIRTH:**_____/_____/_____

PHARMACY INFORMATION - Should Aspire Dermatology need to prescribe medication(s)

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

I would like for my current medications prescribed to me by other service providers to be downloaded electronically from the Surescripts database. **YES** ☐ **NO** ☐

MEDICATIONS/SUPPLEMENTS (Please List)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you currently being treated with class III anti-arrhythmic or Potassium channel blocker drugs for cardiac disorders?
(Such as: Pacerone, Amiodarone, Tikosyn, Defetilde, Sotalol Hydrochloride, Multaq, Dronedarone, Cordarone, Betapace, Corvert, Ibutilide, Nexterone, Sorine or Sotylize) **YES** **NO** ☐ ☐

ALLERGIES (Please list drug allergies, and types of adverse reactions)

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

Smoking Status: please check which option applies:

- Current every day smoker;
- Current someday smoker;
- Former smoker;
- Smoker, current status unknown;
- Never smoker;
- Unknown if ever smoked;

Alcohol use

- Alcohol - none
- Alcohol - less than 1 drink per day
- Alcohol - 1-2 drinks per day
- Alcohol - 3 or more drinks per day

I certify that all the information provided on this date to Aspire Dermatology is correct.

SIGNATURE:_____ **DATE:**_____

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FINANCIAL AGREEMENT

Aspire Dermatology will expect **payment of consultation fees and treatment costs at the time of service**. **Patients with an outstanding balance older than 90 days must make arrangements for payment prior to scheduling appointments. In the absence of a payment plan, collections fees will be applied to the account, and the account will be turned over to a collections agency.**
Aspire Dermatology accepts all major credit cards as a form of payment for your convenience.

Cosmetic Consultation Fee:
Consultation fees are due at the time of the consult and will be deducted from your treatment cost. Consultation fees, product and treatment costs are subject to change without notice.

Non-sufficient Funds Fee:
Aspire Dermatology will charge a $30 NSF fee in the event of a returned or bad check for any and all reasons. The patient will have to make arrangements for all future visits to be paid for either by cash or credit card; a check will no longer be accepted. Please note that as the depositor of the check, Aspire Dermatology gets charged a fee by our financial institution, in the event of a returned or bad check.

Missed Visits:
Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. A **$25.00** missed appointment fee will be added to your account if you do not provide us with the requested 24-hour cancellation or rescheduling notice.

Release of Information:
I authorize Aspire Dermatology to release all or part of my medical records where required by or permitted by law or government regulation, or to any physician(s) responsible for continuing care.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

_____ _____
Signature of Patient or Responsible Party **Print Name**

_____ _____
Relationship to Patient **Date Signed**