

COSMETIC PATIENT INFORMATION
Please Complete All Sections on All Pages

HOME PHONE # _____ Preferred Alternate
 CELL PHONE # _____ Preferred Alternate
 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?

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Very Oily Skin, large pores | <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Sensitive Skin | <input type="checkbox"/> Combination Skin
(Oily T-Zone, dry to normal cheeks) | |

WHAT ARE YOUR AREAS OF CONCERN?

- | | | |
|---|--|---|
| <input type="checkbox"/> Frown lines between eyebrows | <input type="checkbox"/> Acne | <input type="checkbox"/> Sagging Skin |
| <input type="checkbox"/> Crease lines around nose & mouth | <input type="checkbox"/> Freckles/Sun Spots | <input type="checkbox"/> Double Chin |
| <input type="checkbox"/> Wrinkles around eyes/crow's feet | <input type="checkbox"/> Hyperpigmentation | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Forehead lines/creases | <input type="checkbox"/> Facial Hair/Unwanted Hair | <input type="checkbox"/> Vascular Lesions |
| <input type="checkbox"/> Skin Resurfacing | | |
| <input type="checkbox"/> 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: _____

- Do not disclose any information regarding appointments, procedures, results or billing to anyone other than myself

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: _____

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

PAST MEDICAL HISTORY: (Please check all that apply)

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

PREVIOUS COSMETIC PROCEDURES: (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Botox | <input type="checkbox"/> Extractions |
| <input type="checkbox"/> Fillers (Juvederm/Radiesse/Restylane/Voluma) | <input type="checkbox"/> Tattoo Removal |
| <input type="checkbox"/> Kybella | <input type="checkbox"/> Laser Hair Removal |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Skin Resurfacing/Rejuvenation |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Skin Tightening |
| <input type="checkbox"/> Facials | |

WHAT IS YOUR DAILY SKIN CARE REGIMEN? _____

DATE OF LAST SUN EXPOSURE? _____

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, Defetilide, 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:

- | | |
|--|--|
| <input type="checkbox"/> Current every day smoker; | <input type="checkbox"/> Smoker, current status unknown; |
| <input type="checkbox"/> Current someday smoker; | <input type="checkbox"/> Never smoker; |
| <input type="checkbox"/> Former smoker; | <input type="checkbox"/> Unknown if ever smoked; |

Alcohol use

- | | |
|--|---|
| <input type="checkbox"/> Alcohol - none | <input type="checkbox"/> Alcohol - 1-2 drinks per day |
| <input type="checkbox"/> Alcohol - less than 1 drink per day | <input type="checkbox"/> Alcohol - 3 or more drinks per day |

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

SIGNATURE: _____ **DATE:** _____

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