JUPITER DERMATOLOGY & HAIR RESTORATION

Name: ______________________________________ Date of birth: ____/____/_____ Sex: _____
Street address: _______________________________________ City: ________________________
Zip code: ___________ State: ________ Social Security#: _____-____-_______
Daytime phone number: ( ) _____-________ Cell phone number: ( ) _____-________
Marital status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widow

How did you hear about our office? ____

E-Mail Address: ____

Emergency contact information

Name: ______________________________ Home phone number: ( )_____-________
Work phone number: ( )______-_______ Relationship to patient: __________________

Employer information

Occupation: __________________________ Employer name:________________________
Phone number: ( )_____-_______ City, state: ________________________________

Medical history

Arthritis	Glaucoma	Thyroid	Melanoma	HIV+(exposure)
Chronic cough	Asthma/Bronchitis	Chest pain	Hepatitis A/B/C	Heart Murmur
Lymphoma	Squamous Cell	Basal Cell	Diabetes	Emphysema
High Blood Pressure	Cancer of breast/colon/prostate		Other cancers________	Mitral valve prolapse

Reason for today's visit:____
Please list any other medical conditions we need to be aware of: ________________________
Please list any surgical procedures you've had within the last 6 months: _________________
Please list any known allergies: ____
Please list all medications you are currently taking: ___________________________________
____

Do you drink alcohol: ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Are you latex intolerant? ☐ Yes ☐ No
Do you currently use/have used IV drugs? ☐ Yes ☐ No
Do you require antibiotics prior to surgery? ☐ Yes ☐ No
Do you bleed easily? ☐ Yes ☐ No
Do you have artificial joints/pins/screw ☐ Yes ☐ No

Have you ever had dental anesthesia (Novocain)? ☐ Yes ☐ No Any adverse reactions? _____________
Do you have any family history of skin cancer? ☐ Yes ☐ No If yes, what type? __________________

Primary Care Physician:__________________ Primary Care Phone Number: ( )_______-_______
Preferred Pharmacy:_____________________ Pharmacy Phone Number: ( )_______-__________

Patient Signature: ____ Date: _____________________

Physician Signature:_______________________________________ Date:______________________

PLEASE INITIAL

________ I understand that medical care requires my cooperation and I will follow my doctor's orders and prescriptions. I will make and keep appointments for follow-up care and call the office to note any changes or concerns regarding my condition. I authorize my physician and JDHR to take photographs/video tape or by other similar means record my surgery/procedure(s). I understand that reproduction or publication of said photographs and recordings will be used for the purpose of medical/scientific study and research, education, before and after surgical portfolios of the body to demonstrate surgery/procedures and that every effort will be made to protect the patient's identity in those materials. I further acknowledge that all recorded media obtained is that the sole property of JDHR. I hereby certify that I have read the forgoing CONSENT and fully understand the consents thereof.

________ I understand medical consent forms will be provided to me by the doctors and staff of JDHR before treatment. I authorize my doctor to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such medical care to the third party payers, including Medicare. I authorize and request that my insurance company, in lieu or reimbursing me directly, pay to the doctor or medical group any benefits or services. I agree that I may be responsible for payment of all services rendered on my behalf of my dependents. I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have contracted lab or facility, or if services are not covered by my insurance company

Written Acknowledge Form

Receipt of Notice of Privacy Practices

Patient's rights of disclosures: In general the HIPAA privacy rules give individuals the right to request restriction on uses and disclosures of health information. The individual is also provided to the right to request confidential communications of health information be made by alternative means.

(1) I, ___________________________, have received a copy of the Notice of the Privacy Practices
Patient Name

-OR-

(2) has been offered a copy of the Notice of the Privacy Practices but declined to accept a copy.

___________________________ ___________________
Signature of Patient Date

WRITTEN ACKNOWLEDGEMENT OF PATIENT REFUSAL TO SIGN A RECEIPT OF NOTICE OF PRIVACY PRACTICES

On the ___ day of _____________, 2018, the Notice of Privacy Practices was

_____offered and/or given to_____________________________. Patient Name

____ The Patient accepted a copy of the Notice of Privacy Practices but refused to sign an acknowledgement that it was given to the patient.

____ The Patient refused to accept a copy of the Notice of Privacy Practices and refused to sign an acknowledgement that it was offered to the patient.

_________________________________ ___________________

Signature of JDHR Employee-Offering Notice Date

JUPITER DERMATOLOGY & HAIR RESTORATION
LASER & MED SPA
Ricardo Mejia, MD • Ashley Hess, PA-C
561.748.0510
www.jupiterderm.com

Skin Care Questionnaire

1. Please check your skin type:

☐ Type I-	Very Fair/Blue Eyes/Freckles	Always Burn, Never Tan
☐ Type II-	Fair/ Blue, Hazel or Green Eyes	Always burn, Sometimes Tan
☐ Type III-	Cream White/Fair Skinned – Any Eye Color	Sometimes Burn, Always Tan
☐ Type IV-	Moderately Pigmented Olive or Light Brown Skin Tones (Hispanic, Asian, Indian, Middle Eastern, or Mediterranean)	Rarely Burn, Always Tan (Tan stays for months)
☐ Type V-	Darker Brown (Hispanic, Asian, Indian, Middle Eastern, or Mediterranean)	Very Rarely Burns, Tans Very Easily
☐ Type VI-	Darkest Brown/Black	Never Burns, Always Tan

2. Is your skin: ☐Dry ☐Oily ☐Combination

3. Do you currently use sun block? ☐ Yes ☐ No Product Name: ____________ SPF_________

4. Do you currently use Retin A, Tretinoin, or Renova for anti-aging? ☐ Yes ☐ No

5. Do you use any topical antioxidants or Vit C? ☐Yes ☐No Product Name:___________________

6. <u>Are you interested in improving the appearance of your skin?</u> ☐ Yes ☐ No

☐Wrinkles & Fine Lines ☐ Sagging Skin/Volume Loss ☐Jowls ☐ Brown Spots ☐Tone & Texture ☐Pore Size

☐Redness/Broken Blood Vessels ☐Dryness ☐Acne ☐Pre-Cancerous Lesions ☐Removing Tattoos

7. Do you want to look ☐ Refreshed ☐ 5-10 years younger ☐ 10-15 years younger ☐ 20+years younger

8. Do you or have you had facial treatments done? ☐ Yes ☐ No

9. Check which treatment you have had done previously:

☐Facials ☐Microdermabrasion/MicroNeedling ☐Chemical Peels ☐Laser ☐Kybella
☐Botox ☐Fillers (Sculptra, Radiesse, Restylane, Juvederm, Belotero) ☐None

10. What is your current makeup routine? ____

11. What type of foundation do you prefer (liquid, pressed) and what type of coverage (sheer/medium/full)?
____

I am interested in obtaining more information on the following:

☐ **Facial Fillers** (Sculptra,Radiesse, Restylane, Belotero, Juvederm)
___Moderate to severe facial wrinkles and folds

☐ **Hand Rejuvenation** (restore lost volume due to aging)

☐ **CO_2 /ReSurFX Laser**
__ Anti aging skin resurfacing treatment
__ Fractional/Fraxel Lasers

☐ **Sculptra** ___ To improve facial volume
___ To improve sagging skin

☐ **Botox or Dysport**___ Improve the appearance of wrinkles and brow lines
___ Underarm sweating

☐ **Laser Hair Removal**

☐ **Tattoo Removal**

☐ **Kybella** (Neck Fullness/Double Chin Treatment)

☐ **IPL Photo-Facial/Skin Rejuvenation**
___To improve pigmentation/Redness/Stimulate Collagen

□ **Vein Therapy/ Sclerotherapy**
___Eliminate spider and varicose veins.
___Treatment of Facial Veins/Broken Vessels

□ **Skin Care**
___Chemical Peels ___ PRP
___Microdermabrasion/Microneedling
___Facials

□ **Sunscreens ____Chemical Free** (Clear Zinc/Titanium Dioxide)
____Sport/Water Resistant

□ **BluLight**
___ Pretreat cancer lesions

□ **Hair Care/ Hair Transplant**
___Hair Loss/Thinning

□ **Colorescience Mineral Makeup** (Chemical Free SPF)