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 currently use/have used IV drugs?	☐Yes ☐No
Do you smoke?	☐Yes ☐No	Do you require antibiotics prior to surgery?	☐Yes ☐No
Are you pregnant?	☐Yes ☐No	Do you bleed easily?	☐Yes ☐ No
Are you latex intolerant?	☐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:_____

Jupiter Dermatology & Hair Restoration
Cancellation Policy/No Show Policy

1. *Cancellation/ No Show Policy for Appointment*
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. *Scheduled Appointments*
We understand that delays can happen however we must try to keep the other patients and doctors on time.
If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3.*Cancellation/ No Show Policy for Mohs Surgery*
Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.
If surgery is not cancelled at least 10 days in advance you will be charged a seventy five dollar ($75) fee; this is will not be covered by your insurance company.

4. Account balances
We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.
Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.
Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____	_____	____/____/____
Print Name Patient	**Signature Patient/Guardian**	**Date**

JUPITER DERMATOLOGY & HAIR RESTORATION LASER & MED SPA
561.748.0510

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)

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

☐ **CO_2 /ReSurFX Laser**
__Anti aging skin resurfacing treatment
__Fractional/Fraxel Lasers

☐ **Botox or Dysport**
___Improve appearance of wrinkles and brow lines
___Fractional/Fraxel Laser

☐ **Laser Hair Removal**
☐ **Tattoo Removal**
☐ **Kybella** (Neck Fullness/Double Chin Treatment)
☐ **Vein Therapy/ Sclerotherapy**
___Eliminate spider and varicose veins.
___Treatment of Facial Veins/Broken Vessels
☐ **Skin Care**
___Chemical Peels ___ PRP
___Microdermabrasion/Microneedling
___Facials

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

☐ **BluLight**
___ Pretreat cancer lesions

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

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

☐ **Sunscreens** ____**Chemical Free** (Clear Zinc/Titanium Dioxide)
____**Sport/Water Resistant**

JUPITER
DERMATOLOGY &
HAIR RESTORATION
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Ashley Syfer, PA-C • Alli Rayner, PA-C

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent to Jupiter Dermatology & Hair Restoration to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent.

With this consent, Jupiter Dermatology & Hair Restoration may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Jupiter Dermatology & Hair Restoration may mail to my home or other alternative locations any Jupiter Dermatology items that assist the practice in carrying out TPO, such as appointment reminders cards, notices, patient statements as long as they are marked Personal and Confidential. I have the right to request that Jupiter Dermatology restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

_____**By signing this form, I am consenting to Jupiter Dermatology & Hair Restoration use and disclosures of my PHI to carry out TPO.**

_____**I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Jupiter Dermatology may decline to provide treatment to me.**

I acknowledge reading the privacy practice notice above and sign below to accept.

Name of Patient: _____

Signature of Patient/Legal Guardian: _____

Date: _____