



## GUEST HEALTH HISTORY

Fill in this form to the best of your ability; please make notes on the back as this is for informational purposes. This form is merely a beginning of our information gathering process. Our Aesthetician will address your concerns in detail during your 30 minute cosmetic consultation.

TODAY'S DATE \_\_\_\_\_ REFERRAL \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M \_\_\_ F \_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONES/HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

YES  NO Are you currently taking any medications or any herbal products \_\_\_\_\_

YES  NO Do you have allergies to any medications? \_\_\_\_\_

YES  NO Have you ever suffered a severe allergic reaction, explain? \_\_\_\_\_

YES  NO Have you ever had an allergic reaction to local anesthesia, explain? \_\_\_\_\_

YES  NO Do you smoke? How many years? \_\_\_\_\_ How much \_\_\_\_\_/day?

YES  NO Have you ever had cosmetic surgery? List \_\_\_\_\_

YES  NO Do you have cardiovascular or heart disease? \_\_\_\_\_

YES  NO Do you have diabetes? \_\_\_\_\_

YES  NO Do you have seizures? \_\_\_\_\_

YES  NO Do you have hepatitis? \_\_\_\_\_

YES  NO Do you have migraine headaches? \_\_\_\_\_

YES  NO Do you have asthma/hay fever? \_\_\_\_\_

YES  NO Have you ever had herpes, cold sores, fever blisters, keloids, or hives? \_\_\_\_\_

YES  NO Have you been diagnosed with HIV? \_\_\_\_\_

### QUESTIONS RELATING TO SKIN/SKIN CARE

YES  NO Is your family prone to vascular blemishes? Spider Veins \_\_\_\_\_ Varicose leg veins \_\_\_\_\_  
cherry anginoma \_\_\_\_\_ broken facial capillaries \_\_\_\_\_ Rosacea \_\_\_\_\_?

YES  NO Have you ever visited a dermatologist, plastic surgeon, cosmetic dentist, or other skin  
care clinic? List \_\_\_\_\_

YES  NO Have you ever used Retin A or a similar product? \_\_\_\_\_

YES  NO Do you use skin products such as moisturizer, cleanser? What brand \_\_\_\_\_

YES  NO Do you suntan?  
Do you use sunscreen? \_\_\_\_\_

Is your skin:  Dry  Oily  Normal  Combination

Are you  Fair  Olive  Asian  Hispanic  Native American  African American?

What are your concerns with your skin?  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Please answer the following questions by circling the number which best describes you. Your clinician will total the score during the consultation. If skin type V or VI: You need to schedule a SKIN SPOT TEST (Which would mean you have to come in for a consult).

<b>My eye color is:</b>	Light Blue	0
	Blue/Green	1
	Green/Gray/Golden	2
	Hazel/Light Brown	3
	Brown	4
<b>My natural hair color at age 18 was:</b>	Red	0
	Blonde	1
	Light Brown	2
	Medium to Dark Brown	3
	Black	4
<b>The color of my skin that is not Normally exposed to sun is:</b>	Pink to Reddish	0
	Very Pale	1
	Pale with a Beige tint	2
	Light Brown	3
	Medium to Dark Brown	4
	Dark Brown/Black	5
<b>If I go into the sun for an hour or so without sun screen and have not been out in the sun for weeks my skin will:</b>	Burn, Blister, and Peel	0
	Burn, little/no color change when it resolves	1
	Burn, then turns tan in a few days	2
	Get pink, then turns tan quickly	3
	Just tan	4
	Just gets darker	5
<b>When was the last time the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream:</b>	Longer than on month ago	1
	Within the past month	2
	Within the past two weeks	3
	Within the past week	4

<b>Total Score:</b>	<b>If your score is:</b>	<b>Your skin type is:</b>	<b>Notes:</b>
	0-3	I	_____
	4-7	II	_____
	8-11	III	_____
	12-15	IV	_____
	16-19	V	_____
20-24	VI	_____	



## **PATIENT FINANCIAL AGREEMENT**

Thank you for allowing our office the privilege of serving your medical needs. The Woodlands Wellness & Cosmetic Center is a place where the genuine care and welfare of our patients is our highest mission. That is why it is very important that you completely understand our financial policies. Please read the listed information and contact your account representative or our office at any time with questions.

1. You must remit your payment in full at the time the services are rendered.  
For your convenience, we accept cash, checks, Master Card, Visa, Discover and American Express.
2. Returned checks are subject to a \$25 fee. Balances older than 30 days will be subject to collection fees and/or interest charges unless other arrangements have been made. As a member of the Credit Bureau, unpaid balances are reported at our discretion.
3. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Therefore you are ultimately responsible for all charges incurred with our office from the date the services are rendered.
4. If any Pre-certifications are required by your insurance company for allergy testing or treatment, you are responsible to contact them. This is ultimately the responsibility of the patient or insured person, and our office can not be held responsible.
5. Occasionally, insurance companies require your medical records in order to process our claims. By signing below, you are also authorizing the Woodlands Wellness & Cosmetic Center to send your complete medical records to your insurance company once they are requested.

### Notes:

- If you have any questions regarding our financial policies, please don't hesitate to ask us. We are here to help you.
- By my signature, I certify that I have read and agree to the terms of the above and understand I am fully responsible for any charges incurred.
- A Photocopy Of This Document Shall Be Considered As Effective And Valid As The Original.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



## **HIPAA - Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Names and Phone/Fax Numbers of individuals who are authorized to receive my medical information:

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_

- Y N It is ok to send me an e-mail  
Y N It is ok to send me a postcard/flyer/newsletter

For telephone messages on your voicemail or cell phone, please check one of the following:-

1. \_\_\_\_\_ It is OK to leave a message re items such as lab results, vitamins, refills etc.
2. \_\_\_\_\_ Please do not leave specific message but a general message is OK
3. \_\_\_\_\_ Do Not leave any messages at all.

\_\_\_\_\_  
Signature of Patient

or \_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Printed Name of Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

Changes to this document must be submitted in writing. This Form is in compliance with HIPPA guideline. A copy of these guidelines is available upon request.



## PHOTOGRAPH CONSENT

I hereby authorize Woodlands Wellness & Cosmetic Center and staff to take photographs of myself at any time before, during and after the treatment received. Photographs will assist in documenting my progress.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



## No Show/ Cancellation Policy

No Show: If I do not show for my scheduled appointments, I will be billed at full price for the service.

Cancellation Policy: If I cancel **4 hours or less** before my appointment, then I will be charged half of the service price.

I agree to the above statements, and acknowledge the fact that my credit card will be charged if I no-show or cancel within 4 hours of the appointment.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date