PATIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Patient Name _______________________________________ Today's Date____________________

Date of Birth ______________ Age ________ Email ____

Home Address____

City_______________________________ State______________________ Zip Code____________________

Home Phone (______)_____________________ Preferred Number to Contact (_____)______________________

How did you hear about us? ____

MEDICAL HISTORY

Are you currently under the care of a Dermatologist? ☐Yes ☐No Date of last visit ______________________

If yes, for what? ____

Do you smoke? ☐ Yes ☐ No Drink alcohol? ☐ Daily ☐ Occasional ☐ Never

Have you ever been diagnosed with any of the following?

Myasthenia Gravis ☐ Yes ☐ No Multiple Sclerosis ☐ Yes ☐ No Lambert-Eaton Syndrome ☐ Yes ☐No

Have you ever been diagnosed with HIV/AIDS or Hepatitis? ☐Yes ☐No

Any other Neuromuscular Disorder or Autoimmune Disease __________________________________

Do you have: ☐ Diabetes ☐ Liver Disease ☐ Kidney Disease ☐ Cardiovascular Disease ?

Do you have a history of cold sores? ☐Yes ☐No Do you have a history of Shingles? ☐Yes ☐No

Do you have any other health problems or medical conditions? ☐ Yes ☐ No **If yes, please list**:

____

Have you ever had an **allergic reaction** to any of the following? (Please check all that apply and describe the reaction you experienced)

☐ Latex ☐ Aspirin ☐ Motrin ☐ Lidocaine ☐ Hydrocortisone ☐ Hydroquinone or skin bleaching agents

☐ Eggs ☐ Cow's Milk Protein ☐ Shellfish/ Seafood ☐ ANY & ALL Other Medication or Food allergies

(please list)____

List All Drug Allergies____ ☐ No Known Drug Allergies

For our female clients:

Are you pregnant or trying/planning to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Are you currently on any birth control? ☐ Yes ☐ No

MEDICATIONS

Have you ever taken or are you currently taking Accutane? ☐ Yes ☐ No

Please list ALL current medications: ☐ Hormones ☐ Aspirin ☐ Ibuprofen ☐ Blood Thinners

☐ Others: ____

What topical medications or creams are you currently using? ☐ Tretinoin (Retin-A)® ☐ Hydroquinones

☐ Others (Please list): ____

SKIN HISTORY

Have you ever had a professional massage in the past? ☐ Yes ☐ No

Have you had any tanning or sun exposure within the last 4 weeks? ☐ Yes ☐ No

Have you used any self-tanning lotions or treatments within the last 2 weeks? ☐ Yes ☐ No

Do you form thick or raised scars from cuts or burns, or does your skin have difficulty healing? ☐ Yes ☐ No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) ☐ Yes ☐ No

Have you had any previous ☐ IPL Treatment ☐ Photorejuvenation ☐ Laser treatment?

Have you ever had ☐ Facial Implants? ☐ Facial Surgery? If yes, what?___________________________

Have You Ever had Cosmetic Injectables such as Botox, or any facial fillers? ☐ Yes ☐ No

What type of skin do you feel you have? ☐ Dry ☐ Oily ☐ Combination ☐ Sensitive ☐ Acne Prone ☐ Normal

Which of the following best describes your skin type? (Please circle one type number)

I Always burns, never tans

II Always burns, sometimes tans

III Sometimes burns, always tans

IV Rarely burns, always tans

V Brown, moderately pigmented skin

VI Black skin

Ethnicity ______________________________

What are your skin care concerns? ____

Have you ever had a professional skin treatment in the past? (Chemical peel, Microdermabrasion, Dermaplane, etc.)

If yes, please list ____

List any and ALL skin care products you are using: ____________________________________

____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature ____Date: _________________________

Physician Signature ____

Office Policies

We do not see our office policies as restrictions, But rather a necessity of our profession and the professional regulations we promise to uphold. The highest standards of care are necessary for each of our clients, and we provide you with excellent care and the best service we can possibly provide. When you schedule an appointment with Purple Pearl, you are agreeing to our policies, including the terms of our cancellation policy.

Appointments

Scheduling an appointment means you are committed to following through with the time we have scheduled exclusively for you. Should you need to reschedule or cancel your appointment, we require a 24 hour notice. Providing our professional aesthetic services require a great deal of preparation, supplies, and scheduled time. Due to this, we do require a valid credit card at the time of reservation to ensure an adequate cancelation notice. If you provide us with less than a 24 hour reschedule or cancellation notice, you are subject to a $25 fee. If you arrive more than 15 minutes late for your scheduled appointment, we may need to reschedule your service for a different time or date as to keep the remainder of the following scheduled appointments on time for other guests. Please silence all cell phones at the time of arrival. Children age 12 or under may not be left in the waiting area unattended.

Patient/Client paperwork

Please arrive 15 minutes early for your initial service at Purple Pearl to complete necessary forms and paperwork. Although it may seem like a lot of paperwork on your first visit, this is to ensure your health and safety as well as having a full understanding of needs or expectations from your treatments. All necessary forms must be completed in order to perform any service on you at our facility.

Payments

For your convenience, we accept the following forms of payment at Purple Pearl: Cash, Visa, Mastercard, Amex, Discover & Care Credit financing. Patients and clients are required to pay the full fee for services and goods are rendered unless a prepayment has been made. Some services require a deposit or prepayment in full at the time of booking.
We do not accept or bill insurance.

Health Considerations

All patients and clients must be at least 18 years of age or older. Teenage patients undergoing skin treatments will be done at the Aestheticians', and the parents' discretion. Please notify us right away if you become pregnant, planning to become pregnant, or are breastfeeding as we may need to reschedule your treatment for your safety, or alter your at home skin care regimen. Please inform at the time of scheduling if you have a history of fever blisters. We may issue you a medication to take before treatment to prevent a flare-up of symptoms post treatment. We advise patients and clients about the treatments and products that are best suited for their individual needs. Your patient records, treatment plans and personal information are completely confidential.

Treatment Series Pricing

Some aesthetic services are recommended as a series for full benefit and are offered as a series at a reduced cost. All series are non-refundable, unless there is a medical reason you cannot complete treatment. If there is a non-medical reason you do not complete treatment, we will charge the full, non-discounted price for each completed treatment and credit your account with the unused balance. You may use this credit balance for any aesthetic service or product. If a series, package or special includes a free product, and the treatment is not completed, then the retail cost of the product will be deducted from any exchange due.

Gift Certificates / Expiration Dates

All gift certificates expire one year from the purchase date, unless specified otherwise. Any monthly specials and birthday offers are valid in the month advertised only. Gift certificates can be purchased for any denomination. They may be redeemed for services or products. Gift Certificates may not be refunded for cash.

Refund Policy

All sales and services are final; there are no refunds for services performed.

Signature ____ Date: __________________________

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a “friendly” version. A more complete text can be obtained from Merz Medical Services, LLC. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____ date_________________ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature ____ Date: ___________________________