SKINPECCABLE

Medical history questionnaire • Confidential information

PATIENT INFORMATION

Name ____
Last First Middle

Today's Date ____________ Birthdate ____________ Age ____________ ❑ Male ❑ Female

Home Phone (________) ____________ Cell Phone (________) ____________ E-mail ____________

Address ____

City ____________ State ____________ Zip ____________

Social Security #____________ Driver's License # ____________ State ____________

Employer ____________ Business Phone (________)____________

Address ____

City ____________ State ____________ Zip ____________

Occupation ____

Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Ethnicity ❑ Caucasian ❑ African American ❑ Asian ❑ Hispanic ❑ Middle Eastern ❑ Other ____________

How did you learn about Skinpeccable? ____

In Emergency - Contact Name ____________ Phone (________) ____________

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Spouse/Responsible Party ____

Home Phone (________) ____________ E-mail ____________

Address ____

City ____________ State ____________ Zip ____________

Social Security #____________ Driver's License # ____________ State ____________

Cell Phone (________) ____________ Business Phone (________) ____________ Birthdate____________

INSURANCE INFORMATION

Do you have medical insurance? ❑ Yes ❑ No. If yes, please provide us with your card for a photocopy to be made.

Relationship to the insured: ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

Insured's Name____

INSURANCE BILLING IS A COURTESY DONE, BY THIS OFFICE, FOR OUR PATIENTS, AND IN NO WAY RELIEVES YOU OF ANY FINANCIAL RESPONSIBILITY.

I hereby authorize payment to Skinpeccable or its designee surgical and/or medical benefits, if any, otherwise payable to me for their services as described on the attached, but not to exceed the charges stated. I further understand that I am financially responsible for charges not covered by this authorization. I hereby authorize Skinpeccable or its designee to release information required in the course of my examination and/or treatment to my insurance carrier, other MDs, HMOs or IPAs.

Signed ____ Date____________

AUTHORIZATION TO TREAT A MINOR CHILD

I hereby authorize payment to Skinpeccable or his designee to treat my son or daughter, a minor child, in any manner deemed necessary to include examination, treatment and/or surgery if required. This authorization will remain in effect unless written notice terminating authorization is received by this office.

Signed ____ Date____________

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MEDICAL INFORMATION

I. MEDICAL HISTORY

Reason for visit____

____

Do you have now or have you ever had:

	YES	NO
Anemia	❑	❑
High Blood Pressure	❑	❑
Heart Murmur/Palpitaions	❑	❑
Pacemaker	❑	❑
Heart Attack/Angina	❑	❑
Artificial Joint/Heart Valve	❑	❑
Diabetes	❑	❑
Thyroid Problems	❑	❑
Recurrent Yeast Infections	❑	❑
Stroke	❑	❑
Seizures	❑	❑
Seizures with light	❑	❑
Frequent/Severe Headaches	❑	❑
Psychological Problems	❑	❑
Asthma	❑	❑
Bowel Disease/Colitis/Crohn's	❑	❑
Hepatitis/Liver Disease	❑	❑
HIV+	❑	❑
Tuberculosis	❑	❑
Lupus	❑	❑
Hay Fever/Seasonal Allergies	❑	❑
Kidney/Bladder Problems	❑	❑
Prostate Problems	❑	❑
Glaucoma	❑	❑
Bleeding Problems	❑	❑
Cancer other than Skin	❑	❑
Radiation	❑	❑
Past Surgery	❑	❑
Other	❑	❑

If yes to any of the above, please explain:

____

____

____

____

II. MEDICATIONS

List all medications you are taking, including any over-the-counter herbals or vitamins: ____

____

____

III. ALLERGIES

	YES	NO
Are you sensitive/allergic to any medications?	❑	❑

If yes, please list: ____

____

IV. FAMILY HISTORY

Do you have a family history (parents, siblings, children) of:

	YES	NO
Allergies/Asthma	❑	❑
Abnormal ("Dyplastic") moles	❑	❑
Skin Cancer-Basal/Squamous Cell	❑	❑
Skin Cancer-Melanoma	❑	❑
Other Skin Disorder	❑	❑

If yes, which family member_____________________________________

V. SOCIAL HISTORY

Describe your intake of the following:

Caffeine	❑ YES	❑ NO	How often ________________
Alcohol	❑ YES	❑ NO	How often ________________
Smoking	❑ YES	❑ NO	How often ________________
Drugs (Recreational)	❑ YES	❑ NO	How often ________________

VI. DERMATOLOGIC HISTORY

Do you have now or have you ever had:

	YES	NO
Cold Sores/Herpes Infection (Lip Sore)	❑	❑
Keloids/Abnormal Scarring	❑	❑
Reaction to Local Anesthetic	❑	❑
Eczema	❑	❑
Psoriasis	❑	❑
Skin Pigmentation Problems	❑	❑
Abnormal ("Dyplastic") Moles	❑	❑
Precancerous Spots	❑	❑
Skin Cancer-Basal/Squamous Cell	❑	❑
Skin Cancer-Melanoma	❑	❑
Abnormal Cold Sensitivity	❑	❑
Abnormal Sun Sensitivity	❑	❑
Blistering Sunburns	❑	❑

If yes to any above, please explain:

____

____

____

VII. FEMALES

	YES	NO
Are you breast feeding?	❑	❑
Are you pregnant?	❑	❑
Excess Facial/Body Hair	❑	❑
Regular Menstrual Periods	❑	❑

How many Pregnancies? ___________________________________

How many miscarriages/abortions? __________________________

Ages of your children: ____________________________________

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MEDICAL INFORMATION (continued)

VII. COSMETIC HISTORY

Please list your most recent cosmetic and laser procedures and surgeries

Type ______________________________ Date ______________

Type ______________________________ Date ______________

Type ______________________________ Date ______________

Have you used Accutane, Retin A, Renova, Differin, Tazorac or Retinoids in the past 6 months? ❑ Yes ❑ No

If yes, what strength? ______________________________

VIII. SUN EXPOSURE

Do you use sunscreen daily? ❑ Yes ❑ No If yes, what kind? ______________________________

Have you sun tanned in the past 1-2 months? ❑ Yes ❑ No

Do you visit tanning booths? ❑ Yes ❑ No If yes, when was your last visit? ______________________________

Are you using tanning solutions/creams? ❑ Yes ❑ No

Sunburn history: ❑ Always burn ❑ Usually burn ❑ Sometimes burn ❑ Rarely burn ❑ Never burn

Suntan history: ❑ Never tan ❑ Tan with difficulty ❑ Tan average ❑ Tan easily

IX. SKIN CARE

What skin care products do you currently use?

Morning: ______________________________

Evening: ______________________________

Have you ever had any chemical peels/microdermabrasions? ❑ Yes ❑ No

Do you currently get professional facials? ❑ Yes ❑ No

Do you currently get facial waxing, electrolysis or use depilatories? ❑ Yes ❑ No

If yes to above, please describe: ______________________________

Do you have any unwanted:

Hair ❑ Yes ❑ No where? ______________________________

Wrinkles ❑ Yes ❑ No where? ______________________________

Unsightly veins ❑ Yes ❑ No where? ______________________________

Brown spots ❑ Yes ❑ No where? ______________________________

Tattoos ❑ Yes ❑ No where? ______________________________

Red Spots / Redness ❑ Yes ❑ No where? ______________________________

Cellulite ❑ Yes ❑ No where? ______________________________

Is there anything else not listed on this form that you would like to tell us? ______________________________

____

____

This information is correct and accurate to the best of my knowledge:

Patient signature: ______________________________ Date: ______________

Guardian/parent signature: ______________________________ Date: ______________

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SKINPECCABLE

Notice of privacy practice

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health insurance Portability and Accountability Act of 1996 (HIPAA)

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances
The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records, but not including psychotherapy notes. You must submit your request in writing to Raphael Darvish, M.D 11611 San Vicente Blvd., Los Angeles, CA, 90049 or contact number 310-979-SKIN (7546).
4. You may ask us to amend your health information if you believe it is correct or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Raphael Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310-979-SKIN (7546). You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the department of Health and Human Services. To file a complaint with our practice, contact Raphael Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310-979-SKIN (7546). All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Raphael Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310-979-SKIN (7546).

I hereby acknowledge that I have been presented with a copy of Skinpeccable's Notice of Privacy Practice.

Signature ______________________________ Date ________________

Name of patient ______________________________

SKINPECCABLE COMPLIMENTARY COSMETIC CONSULTATION

Skinpeccable physicians offer a complimentary cosmetic consultation to their clients. The scope of this consultation is limited to discussing the technologies (i.e., Cosmetic Lasers) and non-invasive cosmetic procedures (i.e., Botox, Fillers) that can aid clients in attaining more impeccable skin and appearance. Price quotes given for treatments in the initial consultation will be valid for 30 days from the day of the visit.

Discussions beyond the scope described above are not considered part of the cosmetic consult and will be billed standard office visit rates ($120-$150). The evaluation of moles, acne, rashes, hair loss, etc. are considered outside the scope of the cosmetic consult as is any issue requiring a medication prescription.

I understand the above policy regarding Skinpeccable's Cosmetic Consultation.

____

Patient Signature

____

Patient Name

____

Date

SKINPECCABLE 11611 San Vicente Boulevard, Los Angeles, CA 90049
Tel. 310.826.2555 Fax 310.826.2552 www.skinpeccable.com
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SKINPECCABLE

FINANCIAL POLICY

____
Patient Name

To help you understand our financial policy, we have outlined some important factors below.

DEPOSIT

Immediately upon scheduling your procedure, we require a deposit amount of $50. This deposit is applied to your total procedure cost. The date and time of your procedure is subject to change until your deposit is received.

CANCELLING AND RESCHEDULING

If you need to cancel your procedure, we must receive notice ***no less than one (1) business day*** before the scheduled date. If you reschedule or cancel your procedure within one (1) business day of the scheduled time, you will forfeit your deposit and/or credit for one package treatment session. If we do not receive any notice at all, your total deposit and/or credit for one package treatment session will not be refunded.

PAYMENT

For your convenience, we accept cash, Visa, MasterCard, Discover, cashier checks, money orders and personal checks.

Type of card (circle one): Visa MasterCard American Express Discover

Account#____________________________ Exp Date: ________________ Security Code: ________

Billing Address: ________________________ ____________________ ______ ______
Address City State Zip

If paying by personal check, please make check payable to: Raphael Darvish, M.D.

Your signature below indicates that you understand this policy and agree to its terms and conditions.

Patient Signature ____________________________ Date ________________________

Staff Member ______________________________ Date ________________________

THIS AREA INTENDED FOR OFFICE USE ONLY

SKINPECCABLE 11611 San Vicente Blvd., Lobby Level, Los Angeles, CA 90049
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