Parkside OBGYN &
Medical Spa

Patient Questionnaire

Name: _____ Age: _____ Date of Birth: __/__/__ Gender: M F

Address: _____ City: _____ State: _____ Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

E-mail: _____ How did you hear about us?: _____

In case of emergency, whom should we contact? _____ Phone: _____

Medical History

Have you ever had (please check all that apply):

- ☐ Heart disease
- ☐ Heart attack or chest pain
- ☐ Hypertension
- ☐ Heart pacemaker or defibrillator
- ☐ Easy bleeding / bruising, Blood Thinners?
- ☐ Diabetes
- ☐ Delayed or abnormal wound healing
- ☐ Hepatitis
- ☐ Endocrine or hormone disorder
- ☐ Eye conditions
- ☐ HIV or AIDS
- ☐ Current or recent pregnancy
- ☐ Anxiety / Depression
- ☐ Seizures

List any active medical problems you have: _____
List any medications you currently take: _____
List any medication allergies you have: _____
Are you allergic to any metals?: Y__ N__ If so which metals? _____ Are you allergic to latex? Y__ N__
Do you use any tobacco products?: Y__ N__
Has anyone in your family had skin cancer? Y_____ N_____
If YES, who and what type: _____
Do you have a family history of melanoma? Y_____ N_____
If YES, who: _____

Surgical History

List any operations you have had:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Dermatologic History

Have you ever had (please check all that apply):

- ☐ Chronic skin conditions
- ☐ Photosensitivity
- ☐ Keloid or hypertrophic scar
- ☐ Pigmentation disorder
- ☐ Recent waxing / Tweezing
- ☐ Skin cancer
- ☐ Herpes simplex or cold sores
- ☐ Accutane use for acne
- ☐ Tetracycline use for acne
- ☐ Electrolysis or threading
- ☐ Laser skin resurfacing
- ☐ Chemical peel
- ☐ Botox® injection
- ☐ Injection of collagen or other dermal filler
- ☐ Recent sunburn or tan (include tanning bed)

☐ Other? (Please Explain): _____

Do you develop skin rashes or reactions to: Food, Beverages, Adhesives, Antibiotic Ointments, or Environmental Effects (Sun, etc.) Y_____ N_____

If YES explain: _____

Patient Questionnaire (Con't)

Skin Care and Typing

What is your ethnic background? : _____

When exposed to the sun, do you usually:
- ☐ Always burn, never tan
- ☐ Burn easily, tan poorly
- ☐ Tan after initial burn
- ☐ Burn minimally, tan easily
- ☐ Rarely burn, tan darkly easily
- ☐ Never burn, always tan darkly

Do you use sunscreen regularly?: Y_____ N _____

Do you use artificial or "sunless" tanning products?: _____

List any special skin care products you use: _____

Patient Signature: _____ **Date:** _____

Parent or Guardian Signature
(if Patient is under 18 years of age): _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This Notice applies to all records of your care generated and maintained by this medical spa.

We are required by law to: 1) make sure that medical information that identifies you is kept private; 2) make available to you this Notice of our legal and privacy practices with respect to medical information about you; and 3) follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may disclose medical information about you to doctors, nurses, or other personnel involved in taking care of you. We may also disclose medical information to people outside the medical group, such as family members, specialists or others who are involved in providing services that are part of your care.

We may use or disclose medical information about you for operations. These may include use of information to evaluate the performance of our staff, effectiveness of programs, and ways to improve care and services we offer. These uses and disclosures are necessary to ensure that all of our patients receive quality care.

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or care.

We may use or disclose medical information to tell you about or recommend possible treatment options or alternatives, and about health-related benefits, services, events and activities that may be of interest to you.

We may disclose medical information about you to other healthcare providers in the event you need emergency care.

We may disclose medical information about you as required by federal, state or local law.

We may use or disclose medical information to a public health organization or federal organization when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

We may disclose medical information about you in special situations such as for workers' compensation programs, as required by military command authorities or the Department of Veterans Affairs, in response to a court or administrative order, or for public health activities.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may later revoke this permission in writing at any time.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the right to review and receive a copy of medical information that may be used to make decisions about your care. Usually this includes medical and billing records. You must submit a written request to review and copy your medical information. We may charge a fee for the costs of supplying a copy of the records.

You have the right to ask us to amend medical information that you feel is incorrect or incomplete.

Your request for an amendment must be submitted in writing and must provide a reason that supports your request.

We may deny your request for amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information: 1) was not created by us; 2) is not part of the medical information kept by or for us; 3) is not part of the information which you are permitted to inspect and copy; or 4) is not accurate or complete.

You have the right to request an "accounting of disclosures." This is a list of disclosures we have made of medical information about you, with some exceptions. The exceptions are governed by federal health privacy law, and include: 1) routine disclosures for treatment, payment and operations conducted pursuant to your signed consent form; and 2) disclosures to you. You must submit a written request. The request must state a time period that may not be longer than six years and may not include dates before April 14, 2003, when current federal health privacy laws became effective.

You have the right to request restrictions or limitations on the use or disclosure of medical information about you. You must submit a written request for restriction that specifies: 1) what information you want to limit; 2) whether you want to limit our use, disclosure, or both; and 3) to whom you want the limits to apply. We reserve the right to refuse your restriction if it is in conflict with providing you quality healthcare or in an emergency situation.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, such as only at work or by mail. You must submit a written request for confidential communications restrictions, specifying how or where you wish to be contacted. We will accommodate reasonable requests.

You have the right to possess a copy of this Privacy Notice upon request. You may receive a paper copy of this notice, or you can also obtain a copy of this Notice at our offices.

You have the right to file a complaint if you believe your rights to privacy have been violated. All complaints must be submitted in writing. All complaints will be investigated. No personal issue will be raised for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We will post a copy of the current notice at our clinical site.

ACKNOWLEDGMENT OF RECEIPT

Your signature acknowledges you understand and accept the terms and conditions of this notice of Privacy Practices.

In addition to the copy we are providing you, copies of the current notice are available at our office.

I, _____ acknowledge that I have received the Notice of Privacy Practices.
(Print Name)

_____ _____
Signature of Patient or Patient's Representative Date

_____
Relationship to Patient

IF WRITTEN ACKNOWLEDGMENT NOT OBTAINED:

☐ Notice of Practices Given - Patient Unable to Sign
☐ Notice of Practices Given - Patient Declined to Sign
☐ Notice of Privacy Practices and Acknowledgment Mailed to Patient
☐ Other Reason Patient Did Not Sign _____

_____ _____
Signature of Parkside OBGYN & Medical Spa Representative Date

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS / VIDEOS

Medical aesthetics is a visually oriented specialty. For our records and for treatment planning medical photographs are typically taken before, during and after an aesthetic procedure or treatment. In addition we may request video media to accompany these photographs. These photographs support our aesthetic procedure planning and post-procedure evaluation. Photographs and/or videos are required only for the specific treatment areas. Unless the planned treatment is on the face or head, the images typically do not include the face. Consent is required for all patient imaging by Parkside OBGYN & Medical Spa.

Additionally, patients can consent to the release of these photographs and/or videos for potential use in instructional, educational, or promotional materials. These visual materials support our continuing need to insure our current and future patients receive the best treatment and to allow our future patients to understand the planned procedures and, through the use of the visual materials, understand the potential treatment results.

Please read the following release approvals carefully and provide your consent where applicable.

A signature in section 1 is required to receive your care at Parkside OBGYN & Medical Spa. Your signature in section 2, while encouraged, is optional.

SECTION 1: CONSENT TO TAKE PHOTOGRAPHS AND/OR VIDEOS

I hereby authorize Parkside OBGYN & Medical Spa to take pre- procedural, and post-procedural photographs, and/or videos.

I consent to the use of these images for the purposes of pre-procedural planning and post-procedural evaluation by the Parkside OBGYN & Medical Spa aesthetics treatment team.

I, (Print Name)_____ understand that the photographs and/or videos will be made a part of the medical record.

Patient Signature: _____ **Date:** _____

Parent or Guardian Signature
(if Patient is under 18 years of age): _____

SECTION 2: CONSENT FOR RELEASE OF PHOTOGRAPHS AND/OR VIDEOS

I hereby authorize Parkside OBGYN & Medical Spa to use any previously defined photographs and/or videos for professional medical or promotional purposes including but not limited to display by electronic media for training, professional and/or lay publications, presentations to medical or lay groups, or promotional purposes.

Neither I nor any member of my family will be identified by name at any time. Unless it is necessary to include it, my face will not appear in the images. I understand that in some instances the images may portray features which could make my identity recognizable.

I understand my participation is voluntary. I will not be entitled to financial compensation or any other consideration as a result of any use of these images and I hereby release Parkside OBGYN & Medical Spa and any third parties involved in the creation or publication of professional and/or marketing materials, from liability for any claims by me or any third party in connection with my participation. This permission may be rescinded by me at any time to prohibit future use by direct written communication with Parkside OBGYN & Medical Spa management.

☐ I decline to release any photographs and/or videos for non-treatment specific uses by Parkside OBGYN & Medical Spa.

I, (Print Name)_____ understand that I am releasing the right to Photograph and/or video distribution to Parkside OBGYN & Medical Spa.

Patient Signature: _____ **Date:** _____

Parent or Guardian Signature
(if Patient is under 18 years of age): _____

Permission to Contact

Our desire to respect your privacy, please let us know how and if you would like to be contacted by our staff.

We typically confirm with our clients 24 - 48 hours prior to appointments. In addition, 1 – 2 days after treatments or as required, we like to follow-up with our clients. Please check one of the options below for how you would like us to contact you.

Please print your name: _____

Parkside OBGYN & Medical Spa can contact me. I would prefer to be contacted by:

Primary	Secondary	
☐	☐	Telephone: Home: _____ Cell: _____
		Can we leave a voice message? Y_____ N _____
☐	☐	e-mail at: _____
☐	☐	Text at: _____

☐ I prefer not to receive a confirmation or follow-up call or e-mail, and I understand Parkside OBGYN & Medical Spa has the right to charge me for no-show appointments. I also understand that, without a follow-up contact, it will be my responsibility to notify Parkside OBGYN & Medical Spa if I have any concerns or complications after a treatment.

At various times during the year we would like to send mailed communications with our patients. These include such items as thank you notes, notices of special offers and events, educational newsletters and birthday greetings. Please check one of the options below for how you would like us to handle this with you.

☐ I am willing to receive mailings at the address I wrote on my intake form.

☐ I do not wish to receive mailings.

Parkside OBGYN & Medical Spa will be using social media to spread to news on special offers, events and general skin care educational tips from our staff. ***Like us on Facebook and receive a one time special offer!*** If you prefer, we can send this information by e-mail.

☐ I am willing to receive e-mails at: _____

☐ I do not wish to receive e-mails.