CR aesthetics

Last Name:_____ First Name: _____

Date of Birth:_____ Age:_____ E-mail:_____

Address:_____ City:_____ State:____ Zip Code:_____

Home Phone:_____ Cell:_____ Okay to leave voicemail? Yes No

Emergency Contact Name: _____ Relationship:_____ Phone number:_____

Consent to Contact for scheduling and appointment information (Please Circle):

E-mail Cell Phone Home Phone Any of the above

Would you like to receive special offers via text or e-mail? Yes No

Medical Information, Please check all that apply:

Pregnant _____ Nursing _____ Current Smoker _____ Former smoker _____

Sun exposure _____ How often?_____ Artificial Sun_____ How Often?_____

Alcohol Use _____ If yes, how often?_____

List **ALL** current medications (especially Accutane in the last 6 months, Hormone Therapy/ Birth Control, Photosensitizing Drugs):_____

_____

List any Medication or Latex Allergies:_____

Do you have or have you had any past medical problems such as: (Please Circle):

Heart Problems Herpes Diabetes Skin problems/ disease Autoimmune Disease Other

Please Explain: _____

Occupation: _____ Most often inside or outside:_____

Please Circle all treatments that interest you:

Botox Juvaderma Fillers SkinPen Microneedling Dermaplaning Chemical Peels

What is your primary skin concern and goal? _____

How did you hear about our services? _____

Are you a member of a group here at Canyon Ranch? Please Specifiy group name _____

Signature of Guest:_____ Date:_____

Consent to the Use and Disclosure of Health information for Treatment, Payment, or Healthcare Operations

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy.

I understand that as part of my healthcare, this organization originate and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and my plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- and a tool for routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals

The *Notice of Information Practice* provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserved the right to chance their notice and practices and prior to implementation will mail a copy of my revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Consent to Photograph:
I hereby consent to have my photograph taken and give the right and permission to use such photographs for the purposes of documentation.

As our patient we want to know that we respect the privacy of your medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precaution to protect you and provide minimum necessary information to only those we feel are in need of your health care information. We also want you to know that we fully support your full access to your personal medical records. Before and if your information is ever given to anyone, outside this office, your consent will be obtained.

Print Name:_____

Signature:_____Date:_____

Revised_____