CLIENT 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

Client Name ____Today's Date ____________________
Date of Birth ___________________________ Age _________ Occupation ___________________________
Home Address_______________________________ City__________________ State___ Zip Code _______
Phone: Day (____)_________________Cell (____) _______________ Evening (   )_____________________
Email address ____
I would like to receive monthly email newsletters with specials □Yes □ No
Emergency Contact Name and Phone____
Whom can we thank for referring you to us? ____
Do you regularly sun bathe or use tanning salons? ❑ Yes ❑ No   How often?____________________________
When do you plan to be exposed to the sun again?____
What type of sun protection do you use? □ SPF ____
Do you have any upcoming social events?____
_______ (initial) I will notify Dr. Ling of any changes in my address, home or work phone numbers.

MEDICAL HISTORY

Are you currently under the care of a physician? ❑ Yes: Dr. ___________________________ ❑ No
If yes, for what: ____

Do you have or have had any of the following medical conditions? (Please check all that apply)
❑ Herpes /cold sores ❑ Diabetes ❑ HIV/AIDS ❑ Hepatitis ❑ Steroid therapy ❑ High blood pressure
❑ Anticoagulation therapy (aspirin, warfarin) ❑ Blood clotting abnormalities ❑ Pacemaker/defibrillator
❑ Seizure disorder ❑ Tattoo or permanent makeup ❑ Varicose veins ❑ Erythema abigne ❑ Porphyria
❑ Any active infection ❑ Keloid scarring ❑ Skin disease/Skin lesions
❑ Hormone imbalance ❑ Thyroid imbalance ❑ Menstrual disorders (irregular periods) ❑ MTHFR
❑ Cancer __________________❑ Skin Cancer (BCC, SCC, melanoma) ❑ Radiation therapy ❑ Chemotherapy
❑ None of the above ❑Other: ____

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction) ❑ None you experienced) ❑ Food ❑ Latex ❑ Animal Protein ❑ Aspirin ❑ Lidocaine ❑ Hydrocortisone ❑ Botox ❑ Fillers
❑ Hydroquinone or skin bleaching agents ❑ Iodine ❑ Eggs ❑ Others**:** ______________________________

First day of last menstrual period: __________________ ❑ Menopause________ . ____ Pregnancies ____ Births.
List any surgeries: ____

Do you smoke? ❑ No ❑ Yes. If so, _______________________ ❑ cigarettes / ❑ packs per day
Coffee _________ cups/day Tea _________ cups/day Soda _________ cups/day Water _________ cups/day

Where does skincare fit into your day? ❑ once daily ❑ twice daily ❑ other _______________________________
What products do you use? ❑ Cleanser _________________ ❑ Toner ______________________
❑ Serum _____________________ ❑ SPF ____________________ ❑ Moisturizer ___________________
❑ Products containing glycolic, lactic, or any hydroxy acids _____________________❑ Retinoid ____________
❑ Cosmetics ______________________

Client Name: ___________________________________

MEDICATIONS

What oral prescription medications are you presently taking? ❑ Birth control pills ❑ Hormones

____

❑ Others (please list): ____

Have you ever used Accutane? ❑ Yes ❑ No. If yes, when did you last use it? __________________________

What topical medications or creams are you currently using? ❑ RetinA , ❑ Others (Please list):______________

What herbal supplements do you use regularly? ____

COSMETIC HISTORY

Have you ever had laser hair removal? ❑ Yes ❑ No. If yes, when was your last treatment? ________________

Have you used any of the following hair removal methods in the past six weeks?

❑ Shaving ❑ Waxing / Sugaring ❑ Electrolysis ❑ Plucking / Tweezing ❑ Threading ❑ Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? ❑ Yes ❑ No

Have you recently used any self-tanning lotions or treatments? ❑ Yes ❑ No

Do you form thick or raised scars from cuts or burns? ❑ Yes ❑ No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ❑ Yes ❑ No If yes, please describe: ______________________________________

For our female clients:

Are you pregnant or trying to become pregnant? ❑ Yes ❑ No Are you breastfeeding? ❑ Yes ❑ No

Are you using contraception? ❑ Yes ❑ No

SKIN TYPE

Which of the following best describes your skin type?

- ❑ 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

My Concerns: (please check all that apply)

❑ Wrinkles ❑ Acne ❑ Enlarged pores

❑ Brown spots/melasma ❑ Acne scars ❑ Skin growths

❑ Spider veins /rosacea ❑ Thinning skin ❑ Thinning hair

❑ Sagging skin ❑ Thinning lips ❑ Unwanted hair

❑ Unwanted fat ❑ Cellulite ❑ Unwanted tattoo

❑ Weight loss ❑ Loss of volume: ❑ Tear troughs

❑ Other: ______________________________

For our HCG diet / Weight loss clients *(if this does not apply, skip to the bottom to sign):*

Height _________ Weight ________ Method: ❑ Nude ❑ Clothed Scale: ❑ Home ❑ Gym ❑Other______

How much weight do you want to lose?________ lbs

Do you feel the need to eat snacks between meals? ❑ Yes ❑ No

How much do you currently exercise? _____ times per week. Type of exercise: ___________________________

How much water do you currently drink per day? __________________________❑ cups ❑ ounces

How would you describe your diet? ____

How would you describe your weight gain? ____

How would you describe your weight loss attempts? ____

Have you been on the HCG diet previously? ❑ Yes ❑ No Last day of previous treatment? _________________

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional 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. I understand there are no expressed or written guarantees for any of the procedures or medical treatments I receive.

Signature ________________________Printed Name____________________________Date: ________

Parent / Guardian Signature:______________________________Date:_____________________________

Witness____Date:_____________________________

CLIENT INFORMATION & MEDICAL HISTORY

Client Name: _______________________________ Date: __________________________________

Patient consent and acknowledgement of receipt of privacy notice
I understand that as part of the provision of healthcare services, Innate Beauty creates and maintains health records and other information describing among other things: my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. Dr. Shirat Ling takes your confidentiality seriously.

By initialing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made based on my prior consent. This consent is given freely with the understanding that:

______ Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment, or health care operations without any prior written authorization, except as otherwise provided by law.

______ A photocopy or fax of this consent is as valid as this original.

______ I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or health care operations, be restricted. I also understand that the practice and I must agree to any restriction in writing that I request on the use and disclose or my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_______If I discuss my treatment with any third party or on any forum, I waive and nullify all my confidentiality rights

Consent to Treatment and Financial Responsibility

______ I consent to the medical / surgical procedure(s) and treatment(s), including but not limited to anesthesia, laboratory procedures, examinations to be rendered pursuant to the general and special instructions of my physician.

______ I acknowledge that I am legally responsible for all charges in connection with the medical and treatment provided by representatives of Innate Beauty.

______ I understand my insurance carrier or health savings accounts may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, and lack of authorization or medical necessity. I understand I am responsible for fees not paid in full, co-payments, policy deductibles, and co-insurance except when my liability is limited by contract State or Federal laws.

______ Payment is expected in full at the time of service. Patients may pay by Visa, Mastercard, Discover, Amex, Cash or personal checks. Personal checks are not accepted with the initial visit. Please make checks payable to: Dr. Shirat Ling. There is a $25 charge on all returned checks; $50 charge for canceled credit cards; $25 per installment.

Cancellation Policy and Called in Prescriptions

_______A 24 hour notice is required to reschedule or cancel an appointment. If 24 hours notice is not given, a charge of $50.00 per office visit will be assessed on your account. Confirmation emails are made as a courtesy to each patient when possible. Our inability to contact you to confirm your appointment does not constitute an exemption from our cancellation policy. As a courtesy to all patients on time for their appointments, anyone being 15 minutes late or more will need to reschedule their appointment. After the third no-show, the full price of the procedure will be charged to reserve future appointments and is non-refundable in the event of a no-show.

_______A $50 fee is charged when you contact Dr. Ling for a prescription, without an office visit.

_______A $50 fee is charged for email, text, or phone communications exceeding two interactions.

Signature _______________________________________Witness:___________________Date: _______________

Parent / Guardian Signature:______________________________Date:____________________________________

Use of Photographs for Medical Education, Science or Research

Explanation

This consent form authorizes this clinic and individual members of their clinic's staff to use these photographs and/or video footage for medical education teaching or research. Under no such circumstances will any publications or material bear your name. Your refusal to consent to the use of these photographs for medical education teaching or research will in no way influence your treatment.

Consent

I understand the photographs / videos taken of me shall be used for medical records and if in the judgment of the medical health care professional, medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in conjunction with each other. In professional journals or medical books, or used for any other purpose which my health care professional may deem proper in the interest of medical education, knowledge or research.

I waive the rights that I may have to any claims for payment or royalties in connection with any exhibition, televising or publication of these photographs.

I release and hold harmless the clinic, staff and consultants from any liability in connection with the use of such materials.

I understand that the foregoing consent is subject to the following limitation:
Under no circumstances will any such publication, film photograph, video tape or material exhibited contain my name unless voluntarily disclosed by me.

________________________________	________________________________
Signature of patient	Printed Name
________________________________	________________________________
Signature of Parent / Guardian	Printed Name
________________________________	________________________________
Signature of Witness	Date