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 ❑ Sagging Skin ❑ Scars / keloids
❑ Brown spots/melasma ❑ Skin growths ❑ Yellow teeth
❑ Spider veins /rosacea ❑ Thinning skin ❑ Thinning hair
❑ Enlarged pores ❑ Thinning lips ❑ Unwanted hair
❑ Hollow undereyes ❑ Cellulite ❑ Unwanted fat
❑ Urinary incontinence ❑ Vaginal laxity/dryness ❑ Acne
❑ Unwanted tattoo ❑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:_____

Innate Beauty

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 public forum, such as social media, I give Dr. Ling permission to respond in that forum, and, in so doing, 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, Venmo, Zelle, Care Credit, 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 payment. There is a 10% fee added to each Care Credit transaction.

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

Signature _____ Witness:_____ Date: _____
Parent / Guardian Signature:_____ Date:_____

Innate Beauty

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