New Patient Information Packet

(please print clearly and fill out completely)

Last Name: _____First Name: _____MI:_____

Address_____

City: _____ State:_____ Zip:_____

Phone:_____ Alternate Phone:_____

Email: _____ @ _____ . _____

I would like to receive email offers and announcements from LVLL (please circle): Yes No

I would like to receive my appointment confirmations by (please circle): Call Text Email

Who can we thank for your referral: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: M F Other

Social Security Number: _____ -_____ -_____ Ethnicity: _____

Please circle: married single/divorced/widowed minor (under 18)

Emergency Contact: (first and last name): _____

Phone: _____ Relation: _____

FINANCIAL POLICY:

Edward M. Zimmerman, MD, PC, DBA Aesthetic Revolution Las Vegas will accept payment by cash, money order, or credit card. We do not accept personal or bank checks. You must be paid and full at the end of each appointment.

Appointments with Dr. Zimmerman and Dr. Lee continue to require a $100.00 deposit. The $100.00 deposit is applied towards any treatment or product sold in the office, or your next appointment deposit. In the case of a no show, reschedule with less than a 48 hour notice, late cancellation, or late arrival, the $100.00 deposit will not be applied/refunded.

Appointments with practitioners other than Dr. Zimmerman and Dr. Lee are scheduled with a $50.00 deposit. In the case of a no show, reschedule with less than a 24 hour notice, late cancellation, or late arrival, a $50.00 fee will be charged and collected prior to future appointments being scheduled.

A non-refundable 20% deposit is due at the time of booking a surgery date. Surgery must be paid in full two (2) weeks prior to the surgery date. A portion of monies collected may be refunded if surgery is cancelled one (1) week prior and we are able to fill the allowed time slot; otherwise, no refund will be issued.

Medical Records: Records released to the patient will be charged $0.60 per page copied. Payment in full must be received before your records will be released. Please allow ten (10) working days for your records to be copied.

Lab Charges: Lab charges are NOT included in your office visit. Charges for any lab work done in the office will be billed separately by a local lab. You will be getting a bill in the mail from the lab. We forward all billing information to the lab for insurance processing or private billing. If you have any questions, please contact the lab that sent you the bill.

Radiology: Radiology charges are NOT included in your office visit. The office will obtain authorization for any radiology procedures that Dr. Zimmerman or Dr. Lee fees are necessary to your health care. It is ultimately your responsibility to confirm if the facility and procedure is covered by your insurance.

If you have any questions or concerns, please feel free to ask a staff member for clarification.

Signature: _____Todays Date: _____

OFFICE POLICIES:

ACKNOWLEDGEMENT- RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Edward M. Zimmerman, MD, PC, DBA Aesthetic Revolution Las Vegas's "Notice of Privacy Practices." This notice describes how Edward M. Zimmerman MD, PC, DBA Aesthetic Revolution Las Vegas may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Signature of Patient Acknowledgement: _____**Todays Date:** _____

ACKNOWLEDGEMENT- RECEIPT OF PATIENT RIGHTS & RESPONSIBILITIES

I acknowledge that **I have received** a copy of Edward M. Zimmerman, MD, PC, Aesthetic Revolution Las Vegas's "Patient Rights & Responsibilities." This notice describes my rights and responsibilities as a patient of this office.

Signature of Patient Acknowledgement _____**Todays Date:** _____

ACKNOWLEDGEMENT AND CONSENT FOR NEEDLESTICK INCIDENT

I understand that sometimes in the course of treatment there can be an accident, whereby a needle used on me for treatment may somehow stick my caregiver. In the event this would occur, I give my full consent for Dr. Zimmerman and his staff to obtain the necessary blood samples for infectious disease testing recommended by OSHA standards. There will be no cost to me for this testing and I will provided copies of the results for my medical record.

Signature of Patient Acknowledgement: _____**Todays Date:** _____

Patient Medical History: Patient Name: _____

Fill out this form to the best of your knowledge; please circle each answer and explain if necessary.

Have you had any cosmetic surgery or treatments? Yes No If so, what and when? Were you happy with your results? Yes No Why not?
Do you or have you had any surgeries, medical conditions, or extensive dental work we should be aware of? Yes No If so, what and when?
Do you currently have any cold or flue like symptoms? Yes No what type?
Please list all medications, birth control, hormones, herbs, vitamins, and tonics that you are currently taking:
Are you allergic or sensitive to any medicine, food, cosmetics, adhesive tape, or iodine products? Yes No What?
Do you tend to bleed or bruise easily? Yes No
Do you have or have you been exposed to Hepatitis A, B, C, or AIDS/HIV? Yes No
Do you have any problems with your heart or blood pressure? Yes No What?
Have you ever fainted? Yes No When?
Do you have any problems with anxiety or depression? Yes No
Are you claustrophobic? Yes No
Do you frequently travel outside the US? Yes No Where?
How would you rate your stress level? High Moderate Low
How easily do you sunburn? Tan?
When did you last tan in the sun or tanning bed? Use chemical tanners?
Do you have a history of sunburns, sun poisoning, or skin cancer? Yes No
Are you planning an important vacation in the sun? Yes No When?
What is the SPF rating of your sun block or makeup?
What is your daily consumption of alcohol? _____Ounces
What is your daily consumption of caffeine (coffee, tea, or soda)? _____ Cups
What is your daily consumption of water? _____Glasses _____ Bottles

Does anyone in your household smoke? Yes No Inside House/ Outside/ In a car
Do you work in a smoky environment? Yes No
Do you or have you ever smoked? Yes,_____ppd for_____ years; I quit in_____ No
How many hours do you sleep nightly? _____ Is it restful sleep? Yes No
Do you have a history of acne? Yes No My last Breakout was _____
What makes your acne better?_____ Worse? _____
Have you or are taking Accutane? Yes No When?
Have you or are you currently using Retin A or Glycolic Acid? Yes No When?
Do you have a history of cold sores, herpes, fever blisters or shingles? Yes No I generally break out (where and when):
Have you even had chicken pox? Yes No
Do you exercise every week? Yes No Doing what? How often?
Have you maintained the same body weight in the past 5 years? Yes No How much has it fluctuated and how?
Do you get ingrown hairs? Yes No
Do you wax; use a depilatory; have electrolysis; shave; or have laser hair removal done?
Have you had any chemical or laser skin peels done? Yes No What type?
Do you tend to scar or discolor after injuries or skin treatments? Yes No How?
Do you consider your skin to be sensitive? Yes No How?
Do you have oily or dry skin? Dry? Oily? Where?
What brand of skin care and/or makeup do you use?
Do you have any permanent makeup or tattoos? Yes No Where?
Do you have a pacemaker or a defibrillator? Yes No
Have you ever had Gold Therapy for rheumatoid arthritis? Yes No
LADIES ONLY: Are your menstrual cycles regular? Yes No _____ days apart Are you pregnant or planning on becoming pregnant? Yes No When? Do you suffer from menopausal symptoms? Yes No What type? Are you on birth control? Yes No What type?

Date reviewed:_____ Staff Signature:_____