SUMMERLIN
DERMATOLOGY
8310 W Sahara Ave
Las Vegas, NV 89117
P: 702.243.4501 F: 702.243.4701

Aesthetic Patient Form

Name:		Date:
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell:
Age:	Date of Birth:	Occupation:
Email:		

FITZPATRICK CLASSIFICATION SYSTEM: Please select the skin type that seems to best describe your skin

SKIN TYPE	SKIN COLOR	CHARACTERISTICS
❍ I	White	Always burns, never tans
❍ II	White	Usually burns, tans less than average
❍ III	White	Sometimes mild burns, tans about average
❍ IV	Brown	Rarely burns, tans more than average
❍ V	Brown	Rarely burns, tans profusely
❍ VI	Black	Never burns, deeply pigmented

What is your ethnicity? (I.e. Irish, Native American, etc.) This is important for us to determine appropriate treatment setting:

Do you use sunscreen products regularly? YES NO Do you go to a tanning salon? YES NO (Please circle YES or NO)

Do you use self-tanning products? YES NO

WOMEN ONLY (Please circle YES or NO)

Are you pregnant or lactating?	YES	NO
Are you trying to become pregnant?	YES	NO
Did you get hyperpigmentation or masking during pregnancy?	YES	NO
Are you menopausal?	YES	NO

When was the date of your last menstrual period?

PLEASE ANSWER ALL QUESTIONS IN FULL SO WE CAN BETTER SERVE YOU

Have you ever been on Accutane? YES NO If Yes, when were you on it?

What medications are you currently taking*? **This section is required**. Please list any current medications or vitamins.*

Have you used ANY of the following topical medications in the past 7 days?

❍ Retin-A ❍ Bleaching Cream ❍ Doxycycline ❍ Hydroquinone ❍ Antibiotics ❍ Other

Do you get cold sores, fever blisters or herpes outbreak? YES NO If yes, how many per year?

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Do you have any Autoimmune or Neurological disorders? (i.e.: Multiple Sclerosis, Guillain-Barre disease) YES NO (*If yes, please explain).*

Past Medical History

- ❍ Hepatitis
- ❍ HIV
- ❍ HPV/STD
- ❍ Impetigo
- ❍ Other: ____

Any allergies to medications, skin allergies? YES NO (If yes, please explain):

_____

_____

Have you had any other cosmetic surgeries or procedures? YES NO (If *yes, please explain):*

_____

_____

SKINCARE CONCERNS

- ❍ Fine Lines and Wrinkles
- ❍ Crow's Feet
- ❍ Excess Hair
- ❍ Sagging Skin
- ❍ Laugh Lines/Fold Around Mouth
- ❍ Excess Underarm Sweating
- ❍ Skincare
- ❍ Age Spots/Freckles
- ❍ Acne
- ❍ Broken Capillaries on Face or Body
- ❍ Large Pores
- ❍ Rosacea/Facial Redness
- ❍ Leg Veins
- ❍ Spider Veins
- ❍ Other: _____

Have you ever been to a dermatologist? YES NO (If *yes, when and for what purpose?)*

Have you or any member of your family had skin cancer? YES NO (*If yes, who?)*

Do you take vitamins or supplements? YES NO (*If yes, please list)*

Have you ever had laser procedures? YES NO *(If yes, when was your last one?)*

Have you ever had a chemical Peel? YES NO (*If yes, when was your last one?)*

Have you ever had Botox or other fillers? YES NO (*If yes, when was your last one?)*

Please identify the names of the products you currently use:

Cleanser: _____
Moisturizer: _____
Exfoliate: _____
Sunscreen: _____
Toner: _____
Eye Cream: _____
Night Cream: _____

How often do you experience breakouts? FREQUENTLY OCCCASIONALLY RARELY (Please circle one)

Printed Name: _____

Patient Signature: _____

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Summerlin Dermatology Medical Skincare Informed Consent

The skincare treatments such as microdermabrasion, skin peels, facial rejuvenations, IPL laser or other skincare treatment, herein after known as "Clinical Procedure(s)," is not a cure all epidermal treatment. However, for certain skin conditions, these Clinical Procedure(s) can provide marked improvement in the appearance of one's skin. Therefore, it is very important that you have a thorough understanding of what a Clinical Procedure(s) can and cannot do for your particular skin condition. In addition, it is imperative that you acknowledge the potential risks associated with the administration of Clinical Procedure(s).

The foregoing list is not intended to be a complete or exhaustive list of all possible problems or complications, which may arise as a result of the Clinical Procedure(s). Should one or more of the foregoing complications arise, please notify the physician's office immediately.

Discomfort is generally minimal and subsides after a short duration.

Swelling is unusual. If it occurs, it is minimal. Swelling typically subsides in a few hours or a few days, depending on treatment.

Reddening or a **red discoloration** may persist anywhere from a few minutes to several days.

Demarcation is a difference in color, texture, or pigmentation that may occur at the junction between the treated and non-treated skin areas. This is unusual with epidermal procedures.

Existing Blemishes or moles, blood vessels (telangiectasia's), freckles and sun spots may become more obvious and darker since layers of dead skin have been removed. This typically resolves over days or weeks.

Eye Injury caused by chemicals getting into the eye, scarring and vision disturbances are extremely rare. Protective safety goggles are recommended to be worn by you, the patient, while chemicals are being used during all Clinical Procedure(s).

Scarring is very unusual, and very rarely occurs.

Pigmentation changes are rare and usually temporary. Possible permanent changes in the color of the skin rarely occur.

Milia (swollen, clogged pores) may occur, but will usually disappear quickly.

Infection is extremely unlikely, but can happen. Please report immediately.

Herpes Outbreaks may occur in affected individuals with a history of this (if you are prone to cold sores, ask your physician for medication).

Hair Growth: If the Dermaplaning phase of the skin peel is administered, hair is expected to grow back blunt-ended. Underlying hormonal imbalances may affect results. Please discuss with your healthcare provider.

Before subjecting yourself to any Clinical Procedure(s), read carefully the following statements:

1. The Procedure(s) will be explained to me in detail by the physician / or members of the physician's staff.
2. For optimum results, a homecare regimen is needed to enhance the results of the fore mentioned peel.
3. Skincare procedures such as IPL, chemical peels and microdermabrasion are skin rejuvenation treatments. I may need several administrations of this procedure in order to achieve my best results.
4. I understand these procedures need not be administered by a physician. In addition to receiving formal training, any non-physician medical assistant (i.e. Medical Aesthetician) who administers aforementioned skin procedures has had his/her skills reviewed and endorsed by the onsite supervising physician.
5. I understand that it is extremely important to strictly follow all homecare regimen instructions when striving for optimal results.
6. I understand that if I experience any adverse side effects that appear to be attributable to my use of homecare regimen products, I would discontinue use of the products and notify the office immediately.

Patient Printed Name: _____

Patient signature: _____ Date: _____

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Informed Consent for Treatment

Consent to Treat:

I, _____ (Patient's Name), hereby voluntarily request and willingly consent to receive treatment, receive physical examinations and procedures, including aesthetic procedures, performing diagnostic procedures, medical imaging including, but not limited to thermography, and receive diagnosis by the Physician or affiliated clinician at Summerlin Dermatology. I understand that the Physicians and Practitioners will only be working within their scope of practice.

Acknowledgment of Risks:
I understand that the procedures practiced at Summerlin Dermatology are generally considered safe, but may pose certain risks to me. These potential risks may include allergic reaction to supplements and/or pharmaceuticals prescribed to me, muscle soreness following a physical medicine procedure, redness and swelling at site of injection or venipuncture. I agree to contact a staff member of Summerlin Dermatology immediately if I believe any adverse reaction may be occurring due to a treatment that was recommended or performed at this clinic. I will inform my healthcare practitioner of any previous allergic reaction I have had to any pharmaceutical, nutritional supplement, herbal supplement or topical medicine.

I understand that certain nutritional and herbal supplements may be harmful to pregnant women and/or their unborn child. I will inform my healthcare practitioner at Summerlin Dermatology if/when I become pregnant or lactating.

I understand that the recommended procedure is generally very safe and effective, but I realize that there is no guarantee of cure for my medical or aesthetic condition.

Health Insurance and FSA/HSA cards:
I understand that any aesthetic services performed at Summerlin Dermatology will **NOT** be directly billed to my health insurance. Aesthetic services are not typically covered by insurance and I willingly acknowledge that I am responsible for payment of any aesthetic services received. I understand that Flexible Savings Accounts (FSA) and Health Savings Accounts (HSA) may be used for these services, though I understand that it is my responsibility to check with my Human Resources Department through my Employers to know if these services are permitted with my specific policy. Payment in Full is due at time of service.

Hippa/Privacy Policy:
I understand that **my medical record will be kept private**. I understand that the Clinical and support staff at Summerlin Dermatology will have access to my medical record. I acknowledge that my information will never be disclosed to anyone without my consent, except in the case where it is mandated by state law. I understand that I have the right to view my medical chart. I understand that I may request a copy of my medical chart by paying the set fee for photocopying services. I understand that I may request to view the full 'Privacy Policy' per my request.

Signature:
I intend this form to cover my current condition(s), as well as any conditions that may arise in the future that I may seek treatment for at this clinic. By signing this form, I agree to the above statements.

Printed name of Patient: _____

Signature (Patient or legal guardian): _____ Date: _____

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Office Policies

Thank you for choosing Summerlin Dermatology for your healthcare. Please take a moment to read about our office policies. Understanding these policies will help us to best serve you!

Appointments: We have reserved your scheduled appointment time for you and ask that if you need to **cancel** that you need to give us **24 hours advance notice**. If you miss your appointment or cancel with less than 24 hours, we will **charge your account $30**. This fee will be waived for emergency situations.

Payment & Insurance: Payment in full is due at time of service. We will gladly provide you with a service summary for you to self-submit to your insurance company for potential reimbursement. One exception is Motor Vehicle Insurance, which we may bill directly for you. Aesthetic Services will **NOT** be billed to my health insurance company.

Telephone: We are more than happy to have a brief phone conversation to answer your questions. If this phone conversation goes **beyond 10 minutes** or substitutes for an office visit (such as changes made to your treatment plan) you will be billed the same as our normal office visit rates.

Email: If you choose to email your practitioner, please know that email is only intended for brief questions and to clarify treatment plans. Your doctor will typically respond within 1 business day. It is your choice to use email or phone for communication with your doctor.

Supplements: We appreciate your supporting local business by purchasing your high quality nutritional, herbal and homeopathic supplements at Summerlin Dermatology. We strive to keep our prices affordable. Please note that we are **unable to refund** any purchased product once it has left our premise. Please call ahead to pick-up a refill for your supplements, so that we can confirm this item is in-stock.

Prescriptions & Refills: We require patients to **have a follow-up office visit** before we will **refill** prescription drugs. This allows us to make changes to the dosage or treatment as necessary. No new prescription will be given over a phone consult, the patient must be seen in-office first.

Emergency Care: We do **not** provide emergency medical care or after-hours treatment at Summerlin Dermatology. If you are concerned that you may be experiencing a medical emergency, **please call 911**. If you are not experiencing a medical emergency, you may leave a voice message on our office phone 702.243.4501 and we will return your call the next business day.

By signing this form, you are agreeing to the Office Policies at Summerlin Dermatology.

Patient's Signature: _____ Print Patient's Name: _____

Witness Signature: _____ Date: _____