New Patient Intake Form

Aesthetic Treatments

Santana Elite Care

This form is to help us treat you better. Please keep us updated of any changes in your health or medications. Always feel free to ask us any questions that may arise. This form is confidential.

Please complete the following:

Name:____ Date of Birth: ___ / ___ /___

Address:____

City / State / Zip _____________________________________

Home Phone # ______________________________ Cell Phone # ______________________

Email Address:____

How did you hear about us? : ____

Which phone # may we use to contact you? ____

Can we leave a message at this number?: ____

May we speak with your spouse / significant other / family regarding your treatment? Yes / No

Name: ____

May we contact you via Email? Yes No Email address:________________________________

Please advise any additional requests for privacy below:

____

____

Print Client Name: ____

Signature of Client: ____ _____________

(Client/Parent or Guardian if patient is under 18) Date

Please print name if you are the Parent/Guardian:____

Santana Elite Care
Consent For Treatment and Release of Information and Acknowledgment

Consent For Treatment: I hereby authorize the physicians of **Santana Elite Care** in charge of my care to administer such treatment and medication as may be deemed necessary or advisable in the treatment and diagnosis of my condition.

Authorization For Release Of Information for Treatment & Payment: I consent to the use and/or disclosure of my health information to any person or organization for the purpose of treatment, including coordinating my continuing care and as otherwise authorized by law, conducting certain healthcare operations.

Financial Agreement: I understand that I am obligated to pay the account of **Santana Elite Care** in accordance with the regular rates and terms of the organization. I owe and agree to pay **Santana Elite Care** for any and all charges *not* paid by insurance benefits. If my account is not paid, I will pay all court costs, attorney's fees and other costs incurred by **Santana Elite Care** to collect the balance owed. I also authorize payment directly to **Santana Elite Care** for services performed.

____

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, UNDERSTOOD, AND AGREES TO THE FOREGOING, AND IS THE PATIENT OR HIS/HER REPRESENTATIVE

Signature:____ Date:______________________

Signature of Patient or Person Granting Authorization on Behalf of Patient

SANTANA ELITE CARE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers whom may be involved in that treatment, directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have had the opportunity to review your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Middletown Vein and Aesthetic Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Middletown Vein and Aesthetic Center and Radiologic Associates of Middletown at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed in order to carry out treatment, payment, or health care operations.

Patient Name: ____

Signature: ____

Date: _____ / ______ / ______

Santana Elite Care
Photo/Video Release Form

Participants Name: ____

I hereby authorize Middletown Vein and Aesthetic Center to publish the photographs taken of me for use in publications and website. I understand that the photos and or videos will not include my face but rather strictly of the treated areas of my leg(s). I acknowledge that since my participation in publications and websites produced by Middletown Vein and Aesthetics is voluntary, I will receive no financial compensation. I further agree that my participation in any publication and website produced by Middletown Vein and Aesthetics confers upon me no rights of ownership whatsoever. I release Middletown Vein and Aesthetics, its contractors and its employees from liability for any claims by me or any third party in connection with my participation.

Website: www.santanaelitecare.com
Instagram: @santanaelitecare

Signature in agreement: ____

Date:___________________________

Santana Elite Care

Aesthetics Medical History Form

Name: ____________________________ Date of Birth: _____________ Gender: ______

Race/ Ethnicity: __________________________ Marital Status: S M W D

Cell Phone: _________________ Email Address: ____________________________________

Mailing Address: ____

City/State/Zip: _______________________________________

Home Phone: ____________________ Cell Phone: ___________________

Emergency Contact/Relationship: __________________________________

Phone: ___________________________

Medical History

o Cardiac Disease

o Anemia/Bleeding Disorders o Hepatitis

o Diabetes

o Arthritis/Arthralgia

o HIV/AIDS

oHeadaches/Epilepsy/Seizures

o Bruising or Bleeding Disorders

o Thyroid/Autoimmune

o Unexplained Numbness/ Muscle Weakness

o High Blood Pressure

o Hernia/Hernia Repair

o Cancer o Asthma

o Lupus o Pacemaker

o Permanent Metal Implant o Psoriasis

o Nerve/Muscle Issues

o Vitiligo

o Body Piercings

o Tattoos/Permanent Makeup

Other: ____

Skin Concerns - Please check all that apply.

Acne/Acne Scaring

o Eczema o Melasma

o Unwanted Body Hair

o Clogged Pores

o Hyperpigmentation

o Brown Spots/Sun Damage

o Rosacea

o Large Pores

o Skin Laxity

o Dry/ Dehydrated Skin

o Stretch Marks

o Spider Veins

o Fine Lines & Wrinkles

o Skin Texture

o Pigmented Lesions

o Vellus Hair (Peach Fuzz)

o Stubborn Fat

Medications: ____

Which body area(s) or condition would you like treated? ______________________________

Please answer the following questions: 1. Do you have any current or chronic medical illnesses? Yes No Please List:

____

2. Do you have any current or chronic skin conditions? Yes No

____

3. Do you have any allergies to medications, foods, latex or other substances? Yes No Please List: ____

4. Do you smoke? Yes No

5. Do you consume alcohol? Yes No

6. Do you exercise regularly? Yes No

7. Do you get facials, chemical peels or microdermabrasions regularly? Yes No

Which service/when: ____

8. Are you on any form of birth control? Yes No Please List: ________________________

9. Are you pregnant, currently trying to become pregnant, or breastfeeding? Yes No Please Explain: ____

10. Are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder? Yes No Please Explain: ____

11. Are you currently under a doctor's care? Yes No a. For what reason?

____

12. Do you have a history of herpes I or II in the area to be treated (cold sores or blisters)? Yes No

13. Do you have any sexually transmitted diseases? Yes No Please List:

____

14. Do you have a history of keloid scarring or hypertrophic scar formation? Yes No

15. Do you have any unusual reactions or problems with topical anesthesia creams? Yes No Please Explain: ____

16. Do you have or have you ever had any permanent makeup, tattoos, implants or fillers, including but not limited to, collagen, autologous fat, Restylane, etc? Please list where and last date used: ____

17. Do you have or have you had any Botulinums, such as Botox, Dysport, or fillers? Please list where and last date used: ____

18. Have you taken Accutane (or products containing Isotretinoin) in the last 12 months? Yes No Please Explain:

____

I have answered the questions to the best of my knowledge. I understand it is my responsibility to inform the office of my current health conditions while seeking treatment as a patient. I will update this information as it occurs if there are any changes to my health during or in between treatments,

Signature: ________________________________ Date: _________________________________

Beauty Face Chart

FACE

EYES

LIPS

NAME: ____________________

DATE: ____________________