Entered in Millennium _____Scanned to EDM _____

Entered in CC _____

elizabeth roche m.d.
MEDSPA

Name_____ **Date**_____

Date of Birth____/____/_____ **Age**_____ **Male / Female**

Address_____ **City**_____ **Zip Code**_____

Home Phone _____ **Cell Phone** _____

Work Phone_____ **Email**_____

Emergency Contact Name_____ **Phone**_____

How did you hear about us? _____

Medical Information

Allergies_____ **Current Medications**_____

Medical Conditions _____

Pregnant or Nursing? Yes No Are you taking Accutane? Yes No How Long & When?_____

Have you had prior facial surgery? _____**Do you have any facial implants**____ **Where**_____

When was your last Dental appointment: _____ **Do you have Dental Implants:** _____

Have you had any prior Fillers. If so, what Filler where, and who did you go to? _____

Do you have a history of cold sores or the herpes simplex virus? Yes No

Pharmacy_____ **Location**_____ **Phone number**_____

Patient Privacy/HIPAA

We will never share your personal or medical information with any other third party.

May we contact you by the e-mail provided with appointment specifics? Yes No

May we confirm your appointment via text message? Yes No

May we contact you for specials and promotions by the email provided? Yes No

May we contact you via the phone number you provided? Yes No Do we have permission to leave a message with the person who answers the telephone? Yes No

Do we have permission to leave a message on your voicemail? Yes No

Patient Signature _____**Date** _____

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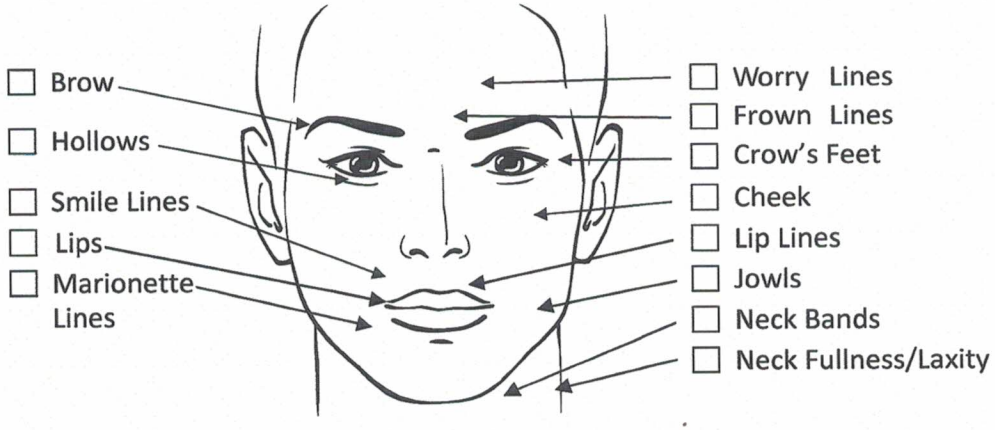
Name: _____ DOB: _____ Referral Source: _____ Date: _____

Your Aesthetic & Skin Concerns:

Please review the list below and CHECK off the areas you have concerns and/or questions about.

Skin & Body

- ☐ Brown Spots
- ☐ Redness
- ☐ Laxity
- ☐ Texture
- ☐ Scarring
- ☐ Dark Circles
- ☐ Pores
- ☐ Veins
- ☐ Loss of Volume
- ☐ Acne
- ☐ Wrinkles
- ☐ Hair Loss
- ☐ Fat Reduction
- ☐ Excessive Sweating
- ☐ Cellulite/Stretch Marks
- ☐ Body Laxity



Cosmetic/Non-Surgical Treaments:

- ☐ Fillers/PDO Threads
- ☐ Wrinkle Relaxers
- ☐ Collagen Stimulators
- ☐ Liquid Facelift
- ☐ Jawline/Neck Contouring
- ☐ Cheek/Profile Enhancement
- ☐ Non-Surgical Chin Augmentation
- ☐ Liquid Nose Job
- ☐ Lip Enhancement
- ☐ Under Eye Enhancement
- ☐ Skin Tightening
- ☐ Kybella
- ☐ SculpSure
- ☐ Skin Tyte
- ☐ Skin Resurfacing
- ☐ Laser Rejuvenation
- ☐ Laser Vein Treatment
- ☐ IPL/BBL/Photofacial
- ☐ PRP Injections/Microneedling
- ☐ PRP for Hair Loss
- ☐ Hydrafacial
- ☐ Dermapeel/Dermaplaning
- ☐ Chemical Peels
- ☐ Microdermabrasion
- ☐ AquaGold Fine Touch
- ☐ Customized Skin Care
- ☐ Earlobe Filler
- ☐ Hand Rejuvenation

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Skin Typing Please circle the numbers below that best describes you

Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Gray, Light Green	Blue, Gray or Green	Dark Blue or Hazel	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut/ Dark Blonde	Dark Brown	Black
What is the color of your skin (non exposed areas)	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None

Total score for **Genetic Disposition** _____

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tans easily	Turns dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

Total score for **Reaction to Sun Exposure** _____

Score	0	1	2	3	4
When was the last time you exposed your body to the sun, tanning beds or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
How frequently do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total score for **Tanning Habits** _____

SUMMARY

_____ Total score for **Genetic Disposition**

_____ Total score for **Reaction to Sun Exposure**

_____ Total score for **Tanning Habits**

_____ **Skin Type Score**

YOUR FITZPATRICK SKIN TYPE

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
Above 30	V - VI

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Appointment and Cancellation Policy

In order to give you and all our patients the best possible care, we request that you review our policy below regarding missed, cancelled or no-show appointments.

A missed/no-show appointment is when you fail to show up for an appointment for an allotted appointment time, without communication. Calling a few hours before a scheduled appointment is considered a cancellation. Not notifying us within 48 hours that you need to reschedule your appointment is considered a cancellation. We request that if you need to reschedule your appointment, that you call us directly at (201) 505-1020 at least 48 hours prior to your scheduled appointment. Patients scheduled for Monday appointments must notify us by 3 p.m. on that Friday before their appointment or leave a message on our voice mail should we be closed.

If you fail to give us notice of your cancellation or cancel within 48 hours before your appointment, you will be charged $50.00.

My signature below acknowledges that I understand all of the above policies.

Patient Signature _____ Date _____

Parent or Guardian if under 18:

Signature _____ Date _____

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HIPAA POLICY

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). 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 who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

You have informed me of your Notice of Privacy Policies, which contains a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address below 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 to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

577 Chestnut Ridge Road, Woodcliff Lake, NJ, 07677|Office (201)505-1020 | Fax (201)505-1080