**The Skincare and Laser Center**
95 Scripps Drive
Sacramento, CA 95825

916-569-0861
Fax: 916-929-6694
www.sacplasticsurgery.com

## Patient Personal Information

Date: _____

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ ☐ Male ☐ Female

Home Phone _____ Cell Phone _____

How did you hear about us?
☐ Friend ☐ Family Member ☐ Website ☐ Facebook ☐ Instagram ☐ Physician

☐ Other_____

## Patient Medical Information

**Patient Medical History**

Please check below if you have ever had or currently have any of the following (check all that apply)

| | | |
|---|---|---|
| ☐ Allergies to medication | ☐ Pacemaker | ☐ Anemia or bleeding problems |
| ☐ Acne | ☐ High blood pressure | ☐ Eczema or atopic dermatitis |
| ☐ Heart disease | ☐ Neuromuscular disorder | ☐ Vitiligo |
| ☐ Skin cancer | ☐ Thyroid disease | ☐ Abnormal moles |
| ☐ Allergies | ☐ Sinus Problems | ☐ Melanoma |
| ☐ Diabetes (Type 1/ Type 2) | ☐ Autoimmune disorder | ☐ History of keloids or thick scars |

The following questions are for female patients only

Are you pregnant? ☐ Yes ☐ No

Are you planning a pregnancy? ☐ Yes ☐ No

Are you on hormone treatments? ☐ Yes ☐ No

**Please list all medications you are taking, including vitamins, pain relievers, and herbal remedies.**

**Please list any surgical procedures you have had.**

**Please list any other medical conditions or problems you may have that were not addressed**

## Skin Questionnaire

**Reason for todays visit?**

**Please answer the following questions.**

Do you use a particular line of skincare products? List all skincare products used.

□ Yes □ No

Do you use skincare products with alpha hydroxy, glycolic acid, retinol or a hydroquinone?

□ Yes □ No □ If yes, what strength?

Have you had any experience with dermal fillers, injectables, or other types of cosmetic procedures (microdermabrasion, laser treatments, etc.)?

□ Yes □ No □ If yes, please specify

Do you regularly apply sunscreen? □ Yes □ Only when outside □ Rarely □ Never

Do you have problems with healing? □ Yes □ No

Do you develop skin rashes in reaction to any of the following? (check all that apply)

□ Medications □ Food □ Environment □ Other

If you answered yes to any of the above please explain:

THE SKIN & LASER CENTER

In response to the many requests for information regarding our practice, we are implementing E-communications with our patients. If you are interested in keeping up with information regarding events, new products or treatments and special savings from our practice, please provide your email below and we will add you to our database.

Your email is confidential and we will not be shared outside our practice.

Name: _____

Email Address: _____

By providing this information I give permission to the office of The Skincare and Laser Center and its affiliates permission to contact me via the email address provided above.

# SKIN TYPING WORKSHEET

**Patient Name**_____ **Date**_____

| SCORE | | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| | What is the color of your eyes? | Light blue or gray | Blue or green | Hazel, Light brown | Dark brown | Brownish Black |
| | What is your natural hair color? | Red, Sandy red | Blonde | Dark blonde, chestnut, brown | Dark brown | Black |
| | What is the color of your skin (unexposed areas)? | Reddish | Very pale | Pale with beige tint | Light brown | Dark brown |
| | Do you have freckles on sun-exposed areas? | Many | Several | Few | Incidental | None |
| | What happens when you stay in the sun too long? | Painful redness, blistering, peeling | Bistering, followed by peeling | Burns, sometimes followed by peeling | Rarely burns | Never had burns |
| | To what degree do you turn brown? | Hardly any or not at all | Light tan | Reasonable tan | Tan very easily | Turn dark brown quickly |
| | Do you turn brown several hours after sun exposure? | Never | Seldom | Sometimes | Often | Always |
| | How does your face respond to the sun? | Very sensitive | Sensitive | Normal | Very resistant | Never had a problem |
| | When did you last expose yourself to the sun, tanning bed or self-tanning creams? | More than 3 months ago | 2-3 months ago | 1-2 months ago | Less than 1 month ago | Less than 2 weeks ago |
| | How often is the area you want to have treated exposed to the sun? | Never | Hardly ever | Sometimes | Often | Always |

| Add above column for Total Score: | Match your Total Score with the corresponding Skin Type. | Fitzpatrick Skin Type |
|---|---|---|
| | 0-7 | I |
| | 8-16 | II |
| | 17-25 | III |
| | 26-30 | IV |
| | Over 30 | V-VI |


# Consent for Photography

Patient Name _____ Account Number _____

I do hereby give permission for photographs to be taken for the purpose of:

Documentation to be filed in my medical chart. These photos will include before and after treatment photographs.

Staff of the Skincare and Laser Center will take the photographs.

Patient Signature_____ Date _____

Witness _____ Date _____

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I also give permission to release my photographs to be used for the purpose of education. This may include presentations to patients or potential patients, lectures to physicians, nurses, used as before and after photos on our website or social media platforms.

Patient Signature_____ Date _____

Witness _____ Date _____

# ACKNOWLEDGEMENT OF PATIENT PRIVACY PRACTICE NOTICE

I have been informed of The Plastic Surgery Center's Patient Privacy Practices. I am aware that this notice describes how medical information about patients may be used and disclosed and how I can get access to this information. I have been requested to review it carefully. I am aware that I have the right to a paper coopy of this notice and may ask for a copy at any time. I may obtain a paper copy of this notice by asking a staff member at the front desk or writing to: The Plastic Surgery Center, 95 Scripps Drive, Sacramento, CA 95825.

I am also aware that my Medical Record may be used in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

Print Name _____ Date_____

Signature of Patient _____

**I authorize The Plastic Surgery Center to release medical information pertaining to my care with the following people other than myself. I will assume responsibility to notify The Plastic Surgery Center, in writing, whenever this information changes.**

Please think about listing the following people on this form:

- **Spouse/Parent/Significant other**
- **Person providing transportation to and from appointments**
- **Person caring for you after surgery**
- **Anyone you may ask to obtain appointment information**

Name Relationship

Name Relationship

Signature of Patient _____ Date_____ Acct. # _____


# CANCELLATION/MISSED APPOINTMENT POLICY

**Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy.**

**Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care.**

**This policy enables us to better utilize available appointments for our patients.**

- Time has been specifically reserved for your appointment, procedure, or treatment.
- You must call at least **36 hours** prior if you need to cancel or reschedule your appointment.
- If you fail to do so you will pay a non-refundable $25.00 deposit when scheduling future appointments.
- If you appear for these appointments as scheduled, your deposit will be credited toward treatment that day.
- If you cancel or reschedule that appointment without 36 hours notice your deposit will be forfeited.
- Deposit fees will be $25.00 for each 30 minutes scheduled.

Print Name_____ Date _____

Patient Signature_____ Acct. # _____