Office Use Only:
_____Booker
_____ Mailchimp
_____ Referral
_____ Driver's License

NEW PATIENT FORM

Today's Date: _____ **Reason(s) for Today's Visit:** _____

Full Name: _____ Date of Birth_____ Age : _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip code)

Email: _____ I consent to my email being added to SCL email list for specials. **Yes** **No**

Home #: (_____)_____ Work Number : (_____)_____

Cell #: (_____)_____ Preferred contact number: ___Home ___Work ___Cell

For appointment text notifications who is your cell provider: (circle one) AT&T Verizon T-Mobile Sprint Alltel Other: _____

(Initial) _____ **Yes** **No** I give SCL permission to contact me through emails, text, and phone regarding my appointments.

(Initial) _____ **Yes** **No** **(PHOTO RELEASE):** I understand photos will be taken. These photos maybe used for education, marketing, and social media such as Facebook, Instagram, YouTube etc. Do we have permission to use your photos?

Gender: (circle one) Male Female **Occupation:** _____

Emergency Contact Information:

Name: _____ Relationship: _____

Telephone Number: (_____)_____

How did you hear about us?

Friend (Name)_____ Newspaper (name) _____ ___Internet

Employee (name)_____ Magazine (name)_____ ___Billboard

Public Event (name) _____ Drive By: _____ ___TV ___Radio Other: _____

How would you rate your overall health? ___ good ___ fair ___ poor

Medical History: Do you have now, or have you ever had any of these diseases or conditions (please circle yes or no).

Anesthesia Problems	Yes	No	Diabetes	Yes	No	Kidney Disease	Yes	No
Anxiety	Yes	No	Dizzy Spells	Yes	No	Liver Disease	Yes	No
Arthritis	Yes	No	Excessive Scarring	Yes	No	Lung Disease	Yes	No
Asthma/Wheezing	Yes	No	Eye Disease	Yes	No	Melanoma	Yes	No
Bleeding Problems	Yes	No	Fainting	Yes	No	Organ Transplant	Yes	No
Blood Clots	Yes	No	Headaches	Yes	No	Pacemaker/Defibrillator	Yes	No
Bone Marrow Transplant	Yes	No	Heart Attack	Yes	No	Phlebitis	Yes	No
Breast Cancer	Yes	No	Heart Murmur	Yes	No	Psychiatric Conditions	Yes	No
Bruise Easily	Yes	No	Hepatitis	Yes	No	Seizures	Yes	No
Chest Pain	Yes	No	High Blood Pressure	Yes	No	Skin Cancer	Yes	No
Colon Cancer	Yes	No	HIV/AIDS	Yes	No	Stroke	Yes	No
Cold Sores/Herpes	Yes	No	Hormone Imbalance	Yes	No	Swelling Hands/Feet	Yes	No
Convulsions/Epilepsy	Yes	No	Irregular Heartbeat	Yes	No	Thyroid Problems	Yes	No
Depression	Yes	No	Keloids (Scars after surgery)	Yes	No	Tuberculosis	Yes	No

If yes on any of the above, please explain: _____

_____

List any other disease or condition we should know about:

_____

List any surgical procedures you have had in the last 5 years. _____

_____

Are you currently under the care of a physician, specialist, chiropractor or dermatologist? ___Yes ___ No
If yes, please list **name** of doctor(s) and **condition** and **date** of last visit.

_____

_____

Female Patients Only: (circle yes or no)

Pregnant	Yes No	Breastfeeding	Yes No	Trying to conceive in next 6 months	Yes No
Using contraceptives	Yes No	Hysterectomy	Yes No	Method of birth control: _____	

MEDICATIONS: Are you taking any of the following: (please circle yes or no).

Antibiotics	Yes No	Coumadin	Yes No	Steroids	Yes No
Anti-coagulants	Yes No	Herbal preparations	Yes No	Thyroid medication	Yes No
Anti-depressants	Yes No	Hormones	Yes No	Vitamins	Yes No
Aspirin	Yes No	Ibuprofen	Yes No	Warfarin	Yes No
Birth control	Yes No	Insulin	Yes No		
Blood pressure medicine	Yes No	NSAIDS	Yes No	Other _____	
Blood thinners	Yes No	Plavix	Yes No		
Cortisone	Yes No	Sedatives	Yes No		

Do you have any metal implants? ___Yes ___No If yes, where? _____

Do you have any artificial joints? ___Yes ___No If yes, where? _____

Prescriptions, Over-the-Counter Drugs, Topicals, Vitamins, Herbs, Supplements, and Recreational Drugs: Please list all meds you are currently using. Attach list if more than five.

Rx: _____ Dosage: _____ Reason: _____

Rx: _____ Dosage: _____ Reason: _____

Rx: _____ Dosage: _____ Reason: _____

Rx: _____ Dosage: _____ Reason: _____

Rx: _____ Dosage: _____ Reason: _____

Skin Disease History: Do you have now, or have you ever had any of these skin conditions (please circle yes or no).

Acne	Yes No	Dry Skin	Yes No	Poison Ivy	Yes No
Actinic Keratoses	Yes No	Eczema	Yes No	Precancerous Moles	Yes No
Allergies	Yes No	Flaking of Itchy Scalp	Yes No	Psoriasis	Yes No
Basal Cell Skin Cancer	Yes No	Hay Fever	Yes No	Skin Rashes	Yes No
Blistering Sunburns	Yes No	Melanoma	Yes No		

If yes to any of the above, please explain: _____

_____

Have you ever used any of the retinoid products? These products are used to treat severe acne:

Accutane	Yes No	Atralin	Yes No	Myorisan	Yes No	Refiissa	Yes No
Adapalene	Yes No	Claravis	Yes No	Renova	Yes No	Tretinoin	Yes No
Amnesteem	Yes No	Hydroquinone	Yes No	Retin-A	Yes No	Other: _____	

If you have used any of these acne products when and how long?_____

What topical products or creams are you currently using? (Please circle products).

Bare Minerals	Glotherapeutics	Mary Kay	Obagi
Clinique	Lancôme	Neutrogena	Olay
Glomineral	Mac	Neocutis	

Other products: _____

Do you wear sunscreen? Yes No If yes, what SPF? _____

Do you tan in a tanning salon Yes No If yes, how often? _____

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes No

Do you suffer from photosensitivity? Yes No

Do you suffer from hyper pigmentation (darkening of the skin) or hypo pigmentation (lightening of the skin)? Yes No

Do you have a history of Keloid scarring? Yes No

Do you have permanent makeup? Yes No

Have you ever had an adverse reaction to laser or any other cosmetic treatment? Yes No If yes, please explain_____

Have you ever had any of the following? (Please circle yes or no).

Botox	Yes No	Facial Surgery	Yes No	Laser Resurfacing	Yes No
Chemical Peels	Yes No	Fillers	Yes No	Microdermabrasion	Yes No
Face Lift	Yes No	Hair Removal	Yes No	Other _____	

If yes to any of the above, what date was the last treatment: _____

Allergies: Have you experienced any allergic reaction to the following? (Please circle yes or no).

Benzocaine	Yes No	Lidocaine	Yes No	Sensitive to Oils	Yes No
Drug Allergies	Yes No	Novocaine	Yes No	Sensitive to Fragrances	Yes No
Food Allergies	Yes No	Seasonal Allergies	Yes No		
Latex	Yes No	Sensitive to Smells	Yes No		

If yes to any of the above, please list specific medication allergies: _____

Do you smoke? ___Yes ___No Do you use recreational drugs? ___Yes ___No

Do you drink alcohol? ___Yes ___No Do you wear contact lenses? ___Yes ___No

To help us determine a treatment plan suitable for you, please describe your skin type (check all that apply).

___Thick	___Normal	___Small Pores	___Mature/Wrinkled
___Thin	___Oily	___Freckled/ Sun Damaged	___Hypo/Hyper-Pigmentation
___Saggy	___Dry	___Uneven Skin Tone	___Acne Scarred
___Firm	___Prone to Breakouts	___Melasma	
___Sensitive	___Large Pores	___Broken Capillaries	

_____ I have received and signed a copy of SCL Policies explaining cancellation, refunds, payments policies, etc.
(Initials)

Patient Consent Agreement:

I affirm that I have stated all my known medical conditions/allergies and have answered all questions honestly. I agree to keep the provider updated as to any changes in my personal/medical profile and understand that there shall be no liability to Southern Cosmetic Laser should I fail to do so. Complications are rare. Should post complications arise necessitating care at a medical or emergency facility, clients are responsible for any and all charges incurred.

I understand all treatments at Southern Cosmetic Laser are considered cosmetic and are completely voluntary and not covered by insurance. Although positive results are expected, there is no guarantee or warranty, expressed or implied of outcome results or patient satisfaction that may be obtained for any service or treatment performed at Southern Cosmetic Laser. Although highly unlikely, it is possible that you may not experience any noticeable results from treatments. I understand there are no specific guarantees concerning expected treatment results. I understand that with any treatment certain risks, complications or side effects from known or unknown causes could occur. I freely assume these risks and acknowledge and agree to hold Southern Cosmetic Laser and its employees harmless against any and all expenses, liability and claims.

I understand that I will be financially responsible for all charges in full at the time I am given treatment unless otherwise discussed before I am seen. Payments are due and payable on day of service. All sales are final. There are no refunds on completed treatment or service sales. Services may be denied if consents and policies are not signed.

Patient's Name (Please Print) _____

Signature of Patient or Legal Guardian: _____

Date: _____

Rev 9-28-18

Southern Cosmetic Laser

HIPAA

With my consent, Southern Cosmetic Laser, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Southern Cosmetic Laser, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised version of any such changes may be obtained by forwarding a written request to the above address. With my consent, Southern Cosmetic Laser, LLC may call my home or any designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements and necessary letters.

With my consent, Southern Cosmetic Laser, LLC may email to my home or any designated location any items that assist the practice in carrying out TPO such as appointment reminders. I have the right to request that Southern Cosmetic Laser, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Southern Cosmetic Laser, LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Southern Cosmetic Laser, LLC may decline to provide treatment to me.

Patient's Name (Please Print): _____

Signature of Patient or Legal Guardian: _____

Date: _____

Southern Cosmetic Laser Policies

New Patient First Appointment:
Please arrive 20 minutes prior to your first appointment time to fill out our New Patient Form or you may download our New Patient Form on our website and bring with you to your appointment. Please bring a list of medications you are currently taking. For your protection against identity fraud, we will need a copy of your driver's license or identification card and a picture will be taken at your first appointment.

Appointment Reminder Policy: Clients receive automated email and text reminders approximately 2 days prior to your scheduled appointment. If you are unable to keep an appointment, please give us a 48-hour notice.

Appointments: Please arrive 10 minutes prior to your appointment. This allows time to check in. If you arrive 15 minutes late, your appointment may have to be rescheduled for another day or your service will be shortened and you will be charged the full price of your scheduled service.

Cancellation & No-Show Policies: All cancellations without a 24-hour notice, no-shows or same-day cancellation may result in a $50 non-refundable rebooking fee added to your next appointment.

Payment: SCL provides cosmetic services (fee for services); therefore, insurance is not accepted. All payments are due and payable on day of service; however, some services may require a deposit in advance. All sales are final. We accept all major debit and credit cards, applicable HSA cards and cash. Sorry, no personal checks.

Prepaid Services: All prepaid treatments must be used and/or in process according to treatment plan within one (1) year of purchase. Any unused treatments will expire and no refunds will be issued. Failure to complete prepaid special package-priced treatments default any credits back to regular pricing.

Complications and Results: Complications are rare. However, should post complications arise necessitating care at a medical or emergency facility, clients are responsible for any and all charges incurred. Although positive results are expected, there is no guarantee or warranty, expressed or implied, of the results that may be obtained for any service, treatment or procedure performed at Southern Cosmetic Laser.

Refund Policy: All treatments, procedures, and services are final. Once a procedure has been provided, there are no refunds. Therefore, before a service is performed, please consider all the required protocols and side effects. Cosmetic services are elective and there are no guarantees as to the outcome results or patient satisfaction. We are committed to client satisfaction and are available to answer any questions or concerns you may have in regards to the services we offer before purchase. Any product purchased at Southern Cosmetic Laser that clients are unable to use due to sensitivity issues must be reported within 21 days of purchase. No make-up products can be returned.

Appointment for a Minor: Minors (under the age of 18) must be accompanied by a parent or legal guardian during their first appointment. A special minor clause can be indicated by a parent or legal guardian for the minor to be seen unattended for any additional appointments.

Southern Cosmetic Laser reserves the right to refuse treatment and/or dismiss a client from any service at any time. It is at the full discretion of Southern Cosmetic Laser to determine whether a client is a candidate for any service provided.

I have read, understand and agree to Southern Cosmetic Office policies set forth.

Patient's Name (Please Print):_____

_____

Patient or Guardian Signature (Date)

Upon request, a copy of these policies can be provided for you. Rev 7-22-18