SKINPECCABLE

Medical history questionnaire • Confidential information

PATIENT INFORMATION

Name _____
Last First Middle

Today's Date _____ Birthdate _____ Age _____ ❑ Male ❑ Female

Home Phone (_____) _____ Cell Phone (_____) _____

E-mail* _____

** Receive promotions in your inbox. We will only email you a maximum of once a month. We never share your information.*

Address _____

City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____ State _____

Employer _____ Business Phone (_____) _____

Occupation _____

Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Ethnicity ❑ Caucasian ❑ African American ❑ Asian ❑ Hispanic ❑ Middle Eastern ❑ Other _____

How did you learn about Skinpeccable? _____

In Emergency - Contact Name _____ Phone (_____) _____

MEDICAL INFORMATION

I. MEDICAL HISTORY

Reason for visit _____

_____

Please list all medical problems:

_____

_____

_____

_____

II. MEDICATIONS

List all medications you are taking, including any over-the-counter herbals or vitamins: _____

_____

_____

III. ALLERGIES

	YES	NO
Are you sensitive/allergic to any medications?	❑	❑

If yes, please list: _____

_____

IV. FAMILY HISTORY

Do you have a family history (parents, siblings, children) of:

	YES	NO
Abnormal ("Dyplastic") moles	❑	❑
Skin Cancer-Basal/Squamous Cell	❑	❑
Skin Cancer-Melanoma	❑	❑

If yes, which family member _____

V. SOCIAL HISTORY

Describe your intake of the following:

Caffeine	❑ YES	❑ NO	How often _____
Alcohol	❑ YES	❑ NO	How often _____
Smoking	❑ YES	❑ NO	How often _____
Drugs (Recreational)	❑ YES	❑ NO	How often _____

VI. DERMATOLOGIC HISTORY

Do you have now or have you ever had:

	YES	NO
Cold Sores/Herpes Infection (Lip Sore)	❑	❑
Keloids/Abnormal Scarring	❑	❑
Reaction to Local Anesthetic	❑	❑
Eczema	❑	❑
Psoriasis	❑	❑
Abnormal ("Dyplastic") Moles	❑	❑
Precancerous Spots	❑	❑
Skin Cancer-Basal/Squamous Cell	❑	❑
Skin Cancer-Melanoma	❑	❑

If yes to any above, please explain:

_____

_____

_____

VII. FEMALES

	YES	NO
Are you breast feeding?	❑	❑
Are you pregnant?	❑	❑
Excess Facial/Body Hair	❑	❑
Regular Menstrual Periods	❑	❑

MEDICAL INFORMATION (continued)

VII. COSMETIC HISTORY

Please list your most recent cosmetic and laser procedures and surgeries

Type _____ Date _____

Type _____ Date _____

Have you used Accutane, Retin A, Renova, Differin, Tazorac or Retinoids in the past 6 months? ❑ Yes ❑ No

If yes, what strength? _____

VIII. SUN EXPOSURE

Do you use sunscreen daily? ❑ Yes ❑ No If yes, what kind? _____

Have you sun tanned in the past 1-2 months? ❑ Yes ❑ No

Do you visit tanning booths? ❑ Yes ❑ No If yes, when was your last visit? _____

Are you using tanning solutions/creams? ❑ Yes ❑ No

❑ Always burn ❑ Usually burn ❑ Sometimes burn ❑ Rarely burn ❑ Never burn

❑ Never tan ❑ Tan with difficulty ❑ Tan average ❑ Tan easily

IX. SKIN CARE

What skin care products do you currently use?

Morning: _____

Evening: _____

Do you have any unwanted:

Hair ❑ Yes ❑ No where? _____

Wrinkles ❑ Yes ❑ No where? _____

Unsightly veins ❑ Yes ❑ No where? _____

Brown spots ❑ Yes ❑ No where? _____

Tattoos ❑ Yes ❑ No where? _____

Red Spots / Redness ❑ Yes ❑ No where? _____

Cellulite ❑ Yes ❑ No where? _____

Is there anything else not listed on this form that you would like to tell us? _____

_____

_____

AUTHORIZATION TO TREAT A MINOR CHILD

I hereby authorize payment to Skinpeccable or his designee to treat my son or daughter, a minor child, in any manner deemed necessary to include examination, treatment and/or surgery if required. This authorization will remain in effect unless written notice terminating authorization is received by this office.

Signed _____ Date _____

This information is correct and accurate to the best of my knowledge:

Patient signature: _____ Date: _____

Guardian/parent signature: _____ Date: _____

SKINPECCABLE

Notice of privacy practice

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health insurance Portability and Accountability Act of 1996 (HIPAA)

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records, but not including psychotherapy notes. You must submit your request in writing to Raphael Darvish, M.D 11611 San Vicente Blvd., Los Angeles, CA, 90049 or contact number 310-979-SKIN (7546).
4. You may ask us to amend your health information if you believe it is correct or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Raphael Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310-979-SKIN (7546). You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the department of Health and Human Services. To file a complaint with our practice, contact Raphael Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310-979-SKIN (7546). All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Raphael Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310-979-SKIN (7546).

I hereby acknowledge that I have been presented with a copy of Skinpeccable's Notice of Privacy Practice.

Signature _____ Date _____

Name of patient _____

SKINPECCABLE

SKINPECCABLE COMPLIMENTARY COSMETIC CONSULTATION

Skinpeccable physicians offer a complimentary cosmetic consultation to their clients. The scope of this consultation is limited to discussing the technologies (i.e., Cosmetic Lasers) and non-invasive cosmetic procedures (i.e., Botox, Fillers) that can aid clients in attaining more impeccable skin and appearance. Price quotes given for treatments in the initial consultation will be valid for 30 days from the day of the visit.

Discussions beyond the scope described above are not considered part of the cosmetic consult and will be billed standard office visit rates ($120-$150). The evaluation of moles, acne, rashes, hair loss, etc. are considered outside the scope of the cosmetic consult as is any issue requiring a medication prescription.

I understand the above policy regarding Skinpeccable's Cosmetic Consultation.

_____

Patient Signature

_____

Patient Name

_____

Date

SKINPECCABLE 11611 San Vicente Boulevard, Los Angeles, CA 90049
Tel. 310.826.2555 Fax 310.826.2552 www.skinpeccable.com

SKINPECCABLE

FINANCIAL POLICY

_____
Patient Name

To help you understand our financial policy, we have outlined some important factors below.

DEPOSIT

Immediately upon scheduling your procedure, we require a deposit amount of $50. This deposit is applied to your total procedure cost. The date and time of your procedure is subject to change until your deposit is received.

CANCELLING AND RESCHEDULING

If you need to cancel your procedure, we must receive notice ***no less than one (1) business day*** before the scheduled date. If you reschedule or cancel your procedure within one (1) business day of the scheduled time, you will forfeit your deposit and/or credit for one package treatment session. If we do not receive any notice at all, your total deposit and/or credit for one package treatment session will not be refunded.

PAYMENT

For your convenience, we accept cash, Visa, MasterCard, Discover, cashier checks, money orders and personal checks.

Type of card (circle one): Visa MasterCard American Express Discover

Account#_____ Exp Date: _____ Security Code: _____

Billing Address: _____ _____ _____ _____
Address City State Zip

If paying by personal check, please make check payable to: Raphael Darvish, M.D.

Your signature below indicates that you understand this policy and agree to its terms and conditions.

Patient Signature _____ Date _____

Staff Member _____ Date _____

THIS AREA INTENDED FOR OFFICE USE ONLY

SKINPECCABLE 11611 San Vicente Blvd., Lobby Level, Los Angeles, CA 90049
Tel. 310.826.2555 Fax 310.826.2552 www.skinpeccable.com