BLUME
SKIN & BODY

CONSULT INTAKE FORM

Name_____ DOB_____/_____/_____ Today's date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone _____Cell _____Work _____

E-mail_____ ***How did you hear about us?*** _____

REASON FOR YOUR VISIT TODAY: _____

MEDICATIONS:
Please list your current prescription medications:_____

Are you using any of the following medications? (i.e. vitamins, fish oils, topical pain creams, lotions, oral antibiotics for acne, anti- aging or hyperpigmentation?**(If yes please list)_____**

Do you take any anti-coagulant (blood thinning) or anti-inflammatory (Advil, etc.) medication? _____Yes _____No

Are you taking Chemotherapy or immunosuppressant medications? ___Yes ___ No (List): _____

Please list any allergies to food or medications: _____

Skin History	**Yes**	**No**		**Skin History**	**Yes**	**No**
Do you tan your skin				Do you have Keloid Scarring		
Do you currently use self- tanning products				Do you have/get cold sores		
History of Skin Cancer				History of Seizures		
History of any type of Cancer				Skin Concerns		

Medical History:

Do you have a current medical diagnosis you are under treatment for? ____ Yes ___No (List)_____

_____

Have you had any facial surgeries or nerve damage to your face? ___ Yes ___No (If Yes:)_____

Do you have a difficult time healing? ___ Yes ___ No

Do you have an active infection of any kind? ___Yes ___ No

Do you have any neuromuscular or autoimmune disease? ___ Yes ___No

Do you have a pacemaker or heart defibrillator? __Yes ___No

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LAST TWO WEEKS:	Yes	No
Any vaccines in the last two weeks?		
Any dental work/visits in the last two weeks?		
Have you taken antibiotics in the last two weeks?		
Have you taken steroids in the last two weeks?		

Are you pregnant or trying to become pregnant? ____ Yes ___No

Have you ever had any of the following injectables or implants?

___Botox: **Last treatment date:_____**

___Facial Filler: **Last treatment date:_____**

___Collagen Stimulators: **Last treatment date:_____**

___ Implants (Breast, Buttock, Chin or Facial Implants) **Last treatment date:_____**

Cancellation Policy:

There will be a $50.00 fee charged to your account if you fail to provide notice of cancellation **at least 48-hours in advance of your scheduled appointment. For Coolsculpting & Ultherapy appointments a fee of $500 (due to length of appointments).**

(After two no-show appointments or two appointments cancelled with less than 48-hour notice you will be discharged from the practice)

Excessive rescheduling of appointments (even within the 48-hour notice) could result in discharge from the practice.

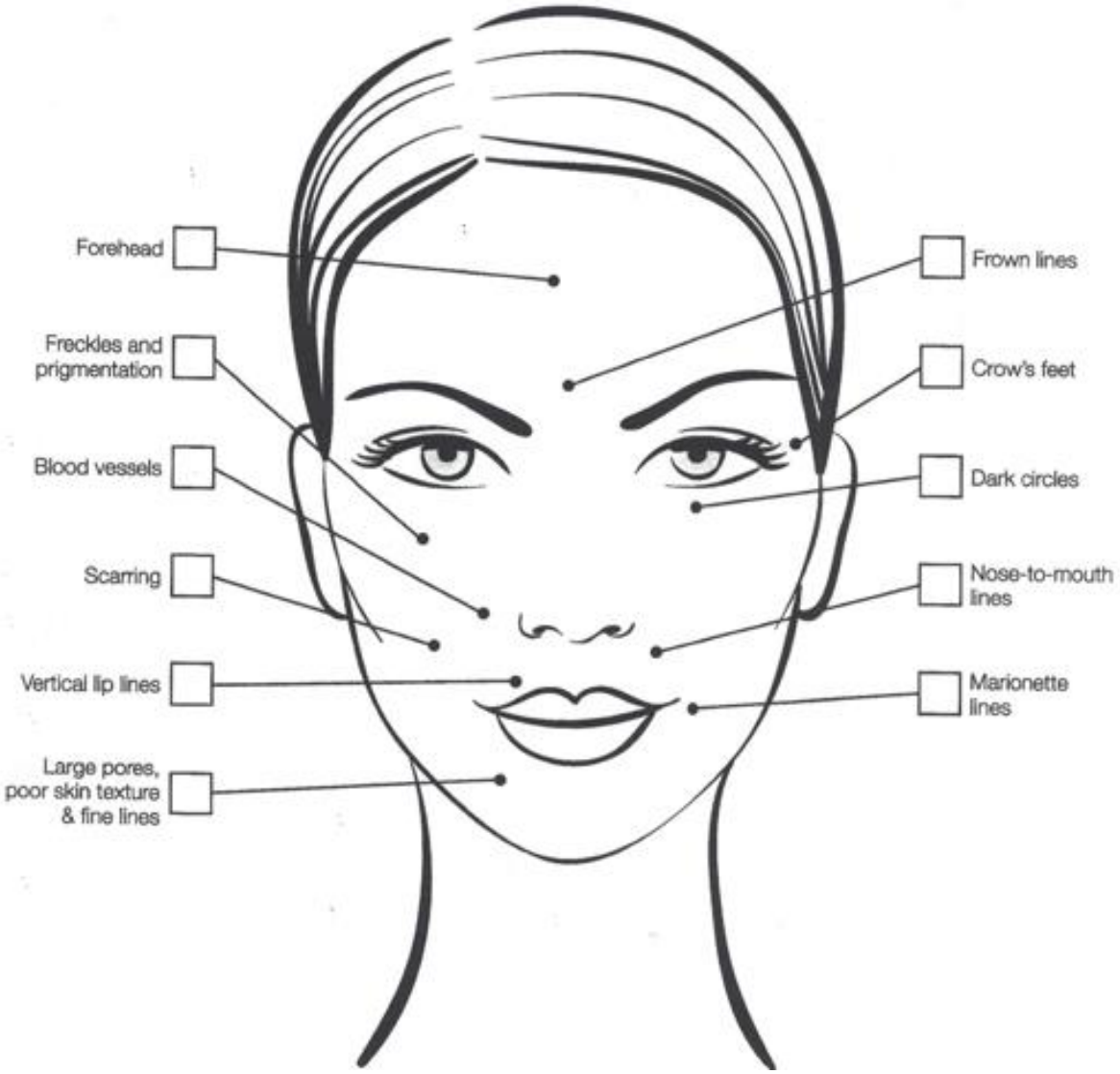
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Blume Skin & Body may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). With my consent, Blume Skin & Body may call my home or other designated location and leave a message on voice mail, text or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder calls. and patient statements. With my consent, Blume Skin & Body may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Blume Skin & Body 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 Blume Skin & Body 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, Blume Skin & Body may decline to provide treatment to me. I consent to receive text messages regarding specials, treatments/treatment questions and events. I also acknowledge the cancellation and no-show policy for Blume Skin & Body.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

With respect to the signs of aging, please highlight those areas of the face that bother or trouble you.



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Media Consent Form

Procedure_____

DOS_____ Patient ID_____

Identifiable Photos

The undersigned hereby authorizes using quotes, testimonials, photos (before and after) for use on special events hosted by Blume Skin Centre, Company Website, Company social media sites (FACEBOOK), email marketing, training, public relations, business development and sales. This will not preclude identifiable photos. This document authorizes use of all of the above for the undersigned's name.

PRINT NAME: _____

SIGNATURE: _____

WITNESS: _____

DATE: _____

Non-Identifiable Photos

The undersigned hereby authorizes using quotes, testimonials, photos (before and after) for use on special events hosted by Blume Skin Centre, Company Website, Company social media sites (FACEBOOK), email marketing, training, public relations, business development and sales. I allow my images to be used, but I do not want my image to be identifiable. This document authorizes use of all of the above for the undersigned's name.

PRINT NAME: _____

SIGNATURE: _____

WITNESS: _____

DATE: _____