



General Information and Confidential Medical History

This information is very important in evaluating your health and recommending appropriate treatment for you. Please answer as completely and accurately as possible. Thank you.

Today's Date _____

Client's Name _____

Address _____
First Middle Initial Last

Street & Apt# City State Zip
Home Phone _____ Cell Phone _____ Other Phone: _____

E-Mail _____ Any Restrictions for contacting you? No Yes _____

Date of Birth _____ Gender Male Female

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

How did you hear about Bella Rosa Rejuvenation Clinic? (Mark all that apply)

Friend/Relative _____ Doctor _____ Website _____ Other _____

If you were referred by a specific person, may we thank them? Yes No

Emergency Contact _____ Relationship to Patient _____

Home/ Cell Phone: _____ Work/ Other Phone _____

Please complete the following items of the medical history. Please, always inform us of any change in you medical history and/or medication.

Please specify your genetic origin:

African American Caucasian Hispanic Mediterranean Middle Eastern Asian
 Native American Other: _____

Medications:

Please list **all medications**, including prescription and over-the-counter, drugs, vitamins, herbs, and/or supplements that you are taking: _____

Have you/are you using the medication **Accutane**? Y N If yes, date of last use _____

Are you using **Rein-A, Renova, Differin, Tazorac**? Y N If yes, what is the concentration? _____%

Allergies:

Are you allergic to any medications? Y N Are you allergic to latex, Lidocaine or any lotions? Y N

If yes, please list all medication reactions: _____

Do you have any skin allergies? Y N If yes, please list: _____

Do you smoke tobacco products? Y N

Medical History: Please check all that apply

Acne	High Blood Pressure	Rosacea
Bleeding disorders	Hirsutism	Seizures
Botox	Hormone Replacement Therapy	Shingles
Burns/ Skin Grafts	Implants	Skin Cancer: Area of Body:
Diabetes	Kaposi's Sarcoma	Tattoos
Endocrine Disorders	Keloid Scars	Thyroid Disease
Epidermolysis Bullosa	Lupus Erythematosus	Vitiligo
Filler Injections	Permanent Makeup	Pacemaker
Gold Therapy	Polycystic Ovary Disease	Other
Heart Disease	Port-Wine Stain	Neuromuscular Disorders
Hemorrhoids	Precocious Puberty	Bell's Palsy
Herpes Simplex (Type I or II)	Psoriasis/ Eczema	Vision Problems: If Yes, List:

Please answer the following questions related to your skin:

- Are you currently being treated for any medical conditions? Y N
Explain: _____
- Do you have active skin diseases or infection in the area to be treated? Y N
- Have you ever had surgery in the area to be treated? Y N
- Have you had any previous laser treatments or other skin treatments in the area to be treated? Y N
Describe: _____
- Does your skin remain discolored after healing from a cut? Y N

Tanning History:

- Do you sunbathe? Y N If yes, approximate date of last sun exposure _____
- Are you currently using, or have you used a tanning bed or self tanner? Y N
If yes, specify with date of last use _____
- Do you use sunscreen? Y N _____ SPF If yes, How often? _____

Hair Removal History:

- Do you use facial depilatories? Y N Last treatment date: _____
- Do you use hot wax to remove facial hair? Y N Date of last waxing: _____

Please indicate concerns you have about your skin: _____

Acknowledgement of Receipt of Privacy Notice

By signing below, you are agreeing that you have been offered a copy of our Privacy Notice, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

By signing below, I authorize Dr. Mark Schusterman / Dr. Patrick Hsu and/or Bella Rosa Rejuvenation clinic and representative(s), to take photographs, slides or videotapes of me or parts of my body for the procedure(s) and for medical purposes to be used for my care, not to be released, published or shared without additional consent.

By signing below, I understand that office visit charges are payable on the day service is rendered. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Schusterman and myself.

By signing below, I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Signature of Client _____ Date _____

Signature of Provider _____ Date _____



Fitzpatrick Skin Type

Name: _____ Date of Birth: _____ Date: _____

	0	1	2	3	4	Score
What is the color of your eyes ?	Light blue, grey or green	Blue, grey or green	Blue	Dark Brown	Brownish Black	
What is the natural color of your Hair ?	Sandy Red	Blond	Chestnut, Dark Blond	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	Blistering followed by Peeling	Burns, Sometimes followed by Peeling	Rarely Burns	Never has Burns	
To what degree do you turn brown?	Hardly or not at all	Light color 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	
Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always	
Score 0-7 8-16 17-25 25-30 Over 30	Fitzpatrick Skin Type I II III IV V-VI				Total Score: Skin Type:	



To maintain a timely schedule and provide patients with the best service possible, we have implemented policies to lessen the occurrence of patients who are late for appointments or who do not show up for scheduled appointments. Showing up late to your scheduled appointment causes patients scheduled behind you to not be seen at the time they expect to be seen. Failing to show up for scheduled appointment causes a missed opportunity for another patient who could have been seen at that time.

No Show Policy for Appointments

Bella Rosa Rejuvenation reserves the right to request a credit card number in order to hold your appointment. **We will charge \$50** if you do not come for your scheduled appointment, reschedule, or cancel your appointment with less than 24 hours notice. If you have prepaid for your procedure, then the \$50 no show fee may be taken out of your prepayment credit for each scheduled appointment that you miss, reschedule, or cancel within 24 hours. You are then responsible for paying the remaining balance prior to your procedure.

Late Policy for Appointments

Since we allot a certain amount of time for each appointment, if you arrive late for your appointment one of two things will occur: 1.) your appointment will end as scheduled, thereby limiting the time available to accomplish the services scheduled for your appointment, or 2.) we will work you into our schedule that day to the extent possible in order to accomplish the services for which you are scheduled, possibly pushing your appointment to the end of the day.

Refund and Cancellation Policy

Bella Rosa Rejuvenation Clinic does not offer refunds on the service(s) I purchase. If I choose to discontinue any service I purchase, the sum of the money I have paid less the treatments received may be applied toward another service offered at Bella Rosa Rejuvenation Clinic, ONLY after review and approval by Bella Rosa Management.

_____**(Initials)** **I have read and understand the policy for No Shows, Reschedules, Cancellations, Late appointments and Refunds, and hereby authorized MD Aesthetic Plastic Surgery and Bella Rosa to keep my signature on file for future charges associated with these policies.**

Printed Name/ Date of Birth

Signature

Date

Signature of Bella Rosa Representative

Date