

# ADVANCED COSMETIC & PLASTIC SURGERY

107 NEWTOWN ROAD, SUITE 2C, DANBURY, CT 06810 (203) 791-9661  
901 ETHAN ALLEN HIGHWAY, SUITE 101, RIDGEFIELD, CT 06877 (203) 438-5080  
22 OLD WATERBURY ROAD, SUITE 106, SOUTHBRURY, CT 06488 (203) 791-9661

## LIGHT SHEER

### Laser Client Information and Medical History

In order to provide you with the most appropriate laser hair removal or skin care treatment, we would appreciate your time in completing the following questionnaire. All information is strictly confidential.

#### PERSONAL HISTORY

Client Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Emergency Contact Name and Phone \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

Which of the following best describes your skin type? (Please circle one skin type number)

- |    |                              |     |                              |    |                                  |
|----|------------------------------|-----|------------------------------|----|----------------------------------|
| I  | Always burns, never tans     | III | Sometimes burns, always tans | V  | Brown, moderately pigmented skin |
| II | Always burns, sometimes tans | IV  | Rarely burns, always tans    | VI | Black skin                       |

#### MEDICAL HISTORY

Are you currently under the care of a physician?  Yes  No

Are you currently under the care of a dermatologist?  Yes  No

Do you have any of the following medical conditions? (Please check all that apply)

- cancer  diabetes  high blood pressure  herpes  arthritis  frequent cold sores  HIV/AIDS  keloid scarring  
 skin disease/ skin lesions  seizure disorder  hepatitis  hormone imbalance  thyroid imbalance  blood clotting abnormalities  
 any active infection

Do you have any other health problems or medical conditions? Please list: \_\_\_\_\_

What oral medications are you presently taking?  ACCUTANE  birth control pill  
 hormones  others (please list): \_\_\_\_\_

Have you ever used Accutane?  Yes  No If yes, when did you last use it? \_\_\_\_\_

What topical medications or creams are you currently using?  Retin A  others (please list) \_\_\_\_\_

Have you ever had laser hair removal?  Yes  No

Have you used any of the following hair removal methods in the past six weeks?

- shaving  waxing  electrolysis  plucking  tweezing  stringing  depilatories

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

Have you recently used any self-tanning lotions or treatments?  Yes  No

Do you form thick or raised scars from cuts or burns?  Yes  No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma?

Yes  No If yes, please describe \_\_\_\_\_

For our Female clients: Are you pregnant or trying to become pregnant?  Yes  No

Are you using contraception?  Yes  No

Are you breastfeeding?  Yes  No

#### Allergies

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced.)

Food  latex  cosmetics  aspirin  lidocaine

hydrocortisone  hydroquinone or skin bleaching agents  others: \_\_\_\_\_

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, aesthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF:  
Notice of Privacy Practices  
Informed Consent  
Practice Financial Policies  
Notice Regarding Ridgefield Surgical Center, LLC**

**ADVANCED SPECIALTY CARE**

107 Newtown Road, Danbury, CT 06810  
131 Kent Road New Milford, CT 06776

901 Ethan Allen Highway, Ridgefield, CT 06877  
22 Old Waterbury Road, Southbury, CT 06488

Privacy Officer: Jennifer Retter, Business Manager (203) 830-4700 ext. 265

I hereby acknowledge that I was given the opportunity to review this medical practice's **Notice Of Privacy Practices (HIPAA)**, and that I have the right to ask for a paper copy of the Notice to take with me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

I authorize the person(s) listed below to discuss my medical information:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

Please note that ASC employees may discuss payment issues with family members or other personal representatives, including the subscriber of my insurance plan, unless I request special privacy protections. My signature on this form authorizes such financial discussion.

Under certain circumstances, this office may need to request lab reports, radiology reports, or other diagnostic test results from outside facilities. At times these facilities may require an authorization to release such records. My signature authorizes the release of any diagnostic test results that we may require in order to provide treatment.

I understand that no procedure provided by this facility is completely without risk and I authorize the care and treatment provided to me under the general or specific directions of my physician or my physician assistant.

**If this office does not have a contract with my insurance company, payment must be made at the time of visit** unless prior arrangements have been made. It is my responsibility to follow up on any outstanding claims sent to my insurance company, and to pay any deductible amount, co-insurance, or any other balance not paid by my insurance company. If services rendered are considered non-covered by my insurance company, I will be responsible for payment in full. My signature on file indicates that I **have read and agree to the terms above**. It is also an authorization to release my medical records, which may include photographs, to those physicians who may be involved in my care, as well as information necessary to process my claims. I hereby authorize payment directly to the physician named of the insurance benefits otherwise payable to me.

I hereby acknowledge that I been given an opportunity to review the posted notice to patients regarding physician ownership of Ridgefield Surgical Center, LLC.

\_\_\_\_\_  
Signature (Parent or Guardian if Patient a Minor)

\_\_\_\_\_  
Relationship To Patient

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Patients Name (if Minor)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient's date of birth