Bella MEDICA by LONGEVITY

## Patient Registration Information

Date: _____

First Name: _____ Last Name: _____

Marital Status: _____ Date of Birth: _____ Gender: M / F

Address: _____

Number and Street City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Best Time to Call: AM or PM

Is it okay to leave a message? Yes or No

Emergency Contact: _____

Name Relation Phone Number

Primary Care Physician: _____

Name Clinic Name Phone Number

Employer: _____ Occupation: _____

How did you hear about us? _____

_____

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# Patient Health History

Patient Name: _____

## Medical History

Please indicate yes (Y) or no (N) for the following:

| | | | | | |
|---|---|---|---|---|---|
| Y/N | Pregnant/Nursing | Y/N | Cancer | Y/N | Excessively tanned skin |
| Y/N | Depression | Y/N | Anxiety | Y/N | Menopause |
| Y/N | Bleeding Disorder | Y/N | Implants-metal or otherwise | Y/N | Varicose Veins |
| Y/N | Stroke/Heart Attack/High BP | Y/N | Hysterectomy | Y/N | Dry Eyes |
| Y/N | Herpes/Cold Sores | Y/N | Asthma | Y/N | Pacemaker/Defibrillator |
| Y/N | Tattoo/Permanent Makeup | Y/N | AIDS/HIV | Y/N | Hepatitis |
| Y/N | Impaired Immune System | Y/N | Spinal Injury | Y/N | Vitaligo |
| Y/N | Edema due to lymphatic draining problems | Y/N | Skin Cancer/Pre-malignant moles | Y/N | Endocrine disorder: Thyroid, Diabetes, hormone imbalances |
| Y/N | Skin disorder: Keloids or abnormal wound healing | Y/N | Active skin infection: eczema, psoriasis, etc. | Y/N | Bleeding disorder or use of anti-coagulants |
| Y/N | Medications/herbs that induce photosensitivity | Y/N | Any surgery in the last 6 months | Y/N | Light-stimulated diseases: Epilepsy/Porphyria/Lupus |

Medications? Y / N

Please list: _____

Allergies? Y / N

Please list: _____

Are there any other considerations you would like us to be aware of? _____

## Skin Care History

Today's treatment interests and skin care concerns: _____

_____

Future treatment interests: _____

Notes: _____

_____

_____

_____

What is your skin type?

☐ Dry ☐ Oily ☐ Combination
☐ Normal

How much water do you consume per day? _____

How much caffeine do you consume per day? _____

Are you using any topical creams, lotions, or oral antibiotics for acne, skin cancer, anti-aging, or hyperpigmentation? Y / N Please list: _____

Please list the products you currently use, and list the brand names of any cosmetic products:

Cleanser _____ Soap _____ Toner _____

Moisturizer _____ Night Cream _____ Mask _____

Eye Cream _____ Astringent _____ Alpha or Beta Hydroxy Cream _____

Scrub _____ Sunscreen _____ _____

Vitamin A Cream _____ Vitamin C Cream _____

Have you undergone any of the following treatments (please check)? ☐ None

☐ Microbermabrasion ☐ Chemical Peel ☐ Cosmetic Surgery
☐ Accutane

Explain: _____

Are you currently removing hair by any of the following methods (please check)?

☐ Waxing ☐ Tweezing ☐ "Nair" type products
☐ Electrolysis ☐ Laser hair removal ☐ Shaving
☐ Bleaching creams

If so, when was it done? _____ What area of the body? _____

Have you ever had any of the following injectables (please check)? ☐ None

☐ Juvederm ☐ Radiesse ☐ Botox
☐ Restylane ☐ Perlane ☐ Silicone
☐ Hylaform ☐ Collagen ☐ Lipo Dissolve
☐ Other:_____

If so, when was it done? _____ What area of the face? _____

Have you had any other cosmetic procedures/surgeries? Y / N

Please list: _____

When? _____ Were you pleased with the results? _____

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# Pre and Post Treatment Instructions

Please initial that you have read and understand the information below.

**Pre-treatment instructions:**

____Three weeks prior to treatment, discontinue waxing or tweezing.

____Three weeks prior to treatment, discontinue any sun exposure, tanning, or tanning lotions.

____One week prior to treatment discontinue Retin-A or glycolic acid products.

____Please shave the area to be treated before your treatment.

____Inform us if there has been any change in your medical history since your last visit.

**Post-treatment information:**

____A cold compress may be applied to reduce redness and swelling.

____If needed, you may continue to shave treated area as normal.

____Do not use Retin-A, glycolic acid or benzoyl peroxide products for one week after treatment.

____Do not wax or tweeze during the course of your treatments.

____Do not expose treated area to the sun. Apply liberal amounts of SPF 45 that may be exposed to the sun.

____Please call the clinic at the first sign of persistent pain or blistering.

**Post-treatment expectations:**

____You may experience a mild sunburn sensation that may last 2-3 hours and redness and swelling that may last 1 day.

____ Appearance of hair growth or stubble will continue for 7-30 days post-treatment. These are treated hairs being expelled from the skin, not new hair growth. You can help the hair to fall out by washing or wiping with a washcloth.

____There may be a risk of paradoxical hair growth in patients with facial hirsutism, an Ovarian Syndrome diagnosis, or are presenting ovarian hyperandrogenism. This results from an activation of the dormant hair follicles in untreated areas near the recently treated areas.

# Fitzpatrick Skin Type Worksheet

| Client Name: | | | | | | Date: |
|---|---|---|---|---|---|---|
| **Determination Based on Your Hereditary Disposition** | | 0 | 1 | 2 | 3 | 4 |
| | What is your eye color? | Light blue or grey | Blue or green | Hazel or light brown | Dark brown | Brownish Black |
| | What is your natural hair color? | Strawberry, red | Blonde | Dark blonde, brown | Dark brown | Black |
| | What is the color of your untanned skin? | Reddish | Very pale | Pale with beige tint | Light Brown | Dark Brown |
| | Are there freckles on your untanned skin? | Many | Several | Few | Incidental | None |
| **Determination Based on Your Sun Exposure** | | 0 | 1 | 2 | 3 | 4 |
| | What happens when you stay too long in the sun? | Painful redness, blistering, peeling | Burns regularly with peeling | Burns, sometimes with peeling | Rarely burns | Never burns |
| | To what degree do you tan in the sun? | Hardly or none at all | Tan a little | Tan reasonably | Tan very easily | Quickly tans to dark shade |
| | Do you turn brown directly after sunbathing? | Never | Hardly | Sometimes | Often | Always |
| | How does your face react to the sun? | Very sensitive | Sensitive | Normal | Very resistant | Never a problem |
| | How often is the area you want to have treated exposed to the sun? | Never | Hardly | Sometimes | Often | Always |
| | 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 16 days ago |

| | Total Score | Fitzpatrick Skin Type |
|---|---|---|
| **TOTAL** | 0-7 | Type I |
| | 8-16 | Type II |
| | 17-25 | Type III |
| | > 25 | Type IV |

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# Consent for Intense Pulsed Light Treatment

StarLux TM Systems deliver a precise pulse of light energy (either laser or lamp) that is absorbed by chromophores in the skin, for example, the pigment in hair, causing a thermal reaction. All personnel in the treatment room, including me, will wear protective eyewear to prevent eye damage from the Intense light energy.

I understand that the pulsed light is intended for cosmetic dermatology treatment, including but not limited to deep tissue heating, soft tissue coagulation, reducing or eliminating hair, pigmented lesions (sun spots and other skin discolorations), vascular lesions (veins), rosacea, and wrinkles. In my situation, it will be used by (physician or technician name) _____. **Initial_____**

I understand that the results vary with each individual and that multiple treatments may be necessary. I understand that the skin's response to this treatment is not 100% predictable and that in some situations a test site will be recommended. This response will guide (physician or technician name) _____ in determining the parameters of my treatment. In spite of satisfactory response at the site, my subsequent response at the treatment site has not been guaranteed. **Initial_____**

The sensation of light is sometimes uncomfortable and may feel like a moderate to severe pinprick or flash of heat. If the licensed practitioner or physician elects to use a local anesthetic, all options will be discussed with me. **Initial_____**

I understand that serious complications are rare, but possible. Common side effects include temporary redness and mild "sunburn" like effects that may last a few hours to 3-4 days or longer. Pigment changes, including hypo-pigmentation (lightening of the skin) or hyper-pigmentation (darkening of the skin), lasting 1-4 months or longer may occur. In addition, freckles may temporarily or permanently disappear in treated areas. Other potential risks include failure to achieve the desired result, crusting, itching, pain, burns, bruising, infection, scabbing, scarring, or swelling. **Initial_____**

I understand that when the device is used for pigmented removal, the treatment area can develop a dark brown scale of devitalized skin, which flakes off in less than 3 weeks. I understand that I should not pick or remove any crusting or scabbing. **Initial_____**

I understand that when the device is used for hair removal, the treatment will be ineffective if the area has been waxed or plucked within 3 weeks of the treatment. The treatment may be ineffective if the target hair is blonde, gray, or has light color. **Initial_____**

I understand that a recent suntan (within two weeks) is likely to result in loss of skin color at the test or treatment site. I have notified (physician or technician name) _____that my last sun exposure or tanning was on _____. I understand that it is my responsibility to advise him/her of my most recent sun exposure before each subsequent treatment is preformed. **Initial_____**

I understand that glycolic acid treatments, Retin-A, Renova, or Obagi programs will adversely influence the skin's response to treatments. I have notified (physician or technician name) _____that my last exposure to any of these products was_____. **Initial _____**

I understand that a fee of $50.00 will be charged for the test site performance and evaluations. If I choose to proceed with treatment, this fee will be deducted from the treatment fee. **Initial _____**

I acknowledge that the fee and estimated number of treatments have been discussed with me. I understand that the number of required treatments may sometimes exceed the estimated number; if so I will be charged a reduced fee for each treatment. **Initial** _____

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion. **Initial** _____

I understand that occasionally, due to environmental or biological circumstances, additional treatments may be prescribed for maximum results. **Initial** _____

I also understand that no person can predict or control environmental or biological circumstances affecting my results. **Initial** _____

I understand that my payment for Intense Pulsed Light Treatment (IPL) is non-refundable. **Initial** _____

Area to be treated _____ Estimated # of treatments _____ Fee for test site _____

Fee per treatment _____ Fee for series _____ Fee for touch up _____

Patient signature_____ Date_____

Witness signature_____ Date_____

## Cancellation/No-Show Policy

We are careful to make sure each patient gets the very best care and our full attention. When patients cancel with little or no notice, or do not show up for appointments, all patients are affected as well as treatment efficiency and quality. However, if given proper notice we are often able to fill those times with another patient from our waiting list.

Therefore, we encourage patient responsibility and practice the following*:

- **Cancellations ($25 fee)** – patients cancelling with less than 24 hours of the appointment time
- **No-show/late or no contact ($50 fee)** – patients who are not present at the appointment time, do not call to reschedule or cancel after the appointment time

I have read the above policy, understand and agree to authorize BellaMedica by Longevity to charge the above stated amount if I should no-show or cancel my appointment without the required notice.

_____
Signature (signature of patient)

_____
Patient Name (please print)

_____
CC number EXP

_____
Name on CC if different from Patient

_____
Signature of Cardholder

*Exceptions will be made for truly extenuating circumstances

# DRIVING DIRECTIONS to our Kirkland Clinic:

**From I-405 Traveling North:** Take the NE 116th Street Exit # 20A

Turn Left onto NE 116th

NE 116th Becomes NE JUANITA DRIVE
Take a Left into the Weidner Building Parking Area

The Clinic is located in Suite 200

**From I-405 Traveling South:** Take NE 124th Street Exit #20

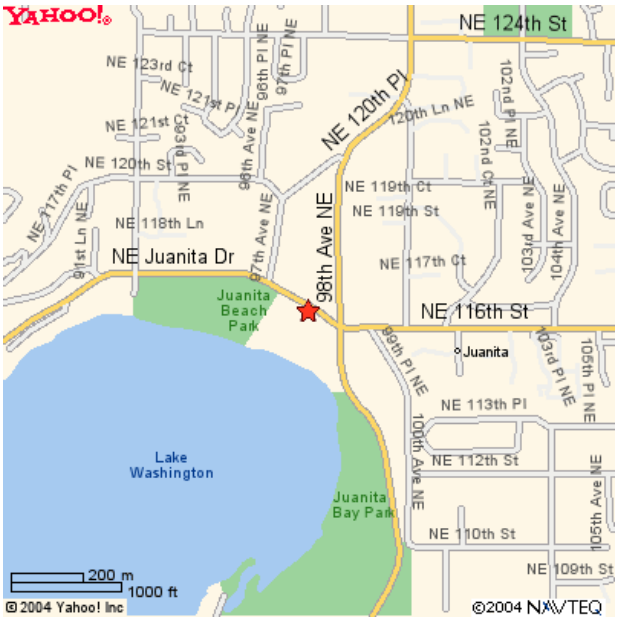
Take a Right onto NE 124th

Turn Left onto 100th Ave NE

Follow arterial taking a right onto NE JUANITA DRIVE

Take an immediate Left into the Weidner Building Parking area

The Clinic is located in Suite 200




*Come and visit us!*

**LONGEVITY MEDICAL CLINIC**
9757 NE JUANITA DRIVE
KIRKLAND, WA 98034
***Call Us! 425· 576· 9272***

Rev. 5/2011