Date: / /

Name: (First)__________ (M.I.)____ (Last) __________ ☐Male ☐Female

Address:__________ Age: ______ D.O.B: / /

City:__________ State: ______ Zip: ______

Social Security #: __________ Home: __________ Cell: __________

Marital Status: ☐Single ☐Married ☐Other E-mail: __________

Primary Care Physician: __________

EMERGENCY CONTACT

Name: (First)__________ (Last) __________ Relationship to Patient: __________

Address:__________ Home: __________ Cell: __________

City: __________ State: ______ Zip: ______

HOW DID YOU HEAR ABOUT US

- ☐ Coupon Campaign
- ☐ Established Patient
- ☐ Facebook
- ☐ Other Social Media
- ☐ Friends / Family
- ☐ Gift Certifictae
- ☐ Internet Search
- ☐ Office Party
- ☐ Radio
- ☐ TV
- ☐ Other: __________

REASON FOR VISIT

- ☐ Acne
- ☐ Balding / Hair Loss
- ☐ Double Chin
- ☐ Deep or Fine Wrinkles
- ☐ Enlarged or Clogged Pores
- ☐ Hidradenitis Suppurativa
- ☐ Melasma
- ☐ Rosacea
- ☐ Saggy Skin
- ☐ Scars
- ☐ Skin Cancer
- ☐ Spider or Varicose Veins
- ☐ Sun / Brown / Aged Spots
- ☐ Thin / Absent Eyebrows
- ☐ Thin Eye Lashes
- ☐ Unwanted Hair

OUR SERVICES

NON-SURGICAL FACIAL Rx

- ☐ Botox®
- ☐ Dermal Fillers
  - ☐ Juvéderm®
  - ☐ Radiesse®
  - ☐ Restylane®
  - ☐ Sculptra®
- ☐ Kybella®
- ☐ Latisse®
- ☐ NovaThreads® Face Lift & Body Sculpting

SPA SERVICES

- ☐ Facials
- ☐ Custom Peels
- ☐ Dermaplaning
- ☐ Lash Extensions
- ☐ Waxing

HAIR RESTORATION

- ☐ FUE Transplant
- ☐ FUT Transplant
- ☐ Hair growth Rx
- ☐ Capillus® Laser Hair Cap
- ☐ Platelet-Rich Plasma (PRP) Rx

LASER COSMETIC TREATMENTS

- ☐ CoolGlide® Laser Hair Removal
- ☐ Limelight Facial™
- ☐ Laser Genesis™
- ☐ Laser Vein & Sclerotherapy

COSMECEUTICALS

- ☐ IMAGE Skincare

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PAST MEDICAL HISTORY

Do you have any chronic medical problems? (Check all that apply)

- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Emphysema
- ☐ Gastric Reflux
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV or AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Polycystic Ovaries
- ☐ Psychiatric Condition
- ☐ Seizures
- ☐ Skin Disorder
- ☐ Skin Rashes
- ☐ Stroke
- ☐ Stomach Problems
- ☐ Thyroid Problems

Past surgical and cosmetic treatments	Date	List Any Complications:
1. ______________________	/ /	______________________
2. ______________________	/ /	______________________
3. ______________________	/ /	______________________

Medications or dietary supplements:*

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Allergies:

____
____
____
____
____

*Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil, St. John's Wort, Accutame, Retin A or Doxycline

SOCIAL HISTORY

- ☐ Yes ☐ No Aspirin or medications containing aspirin, Aleve, ibuprophin
- ☐ Yes ☐ No Blood thinners?
- ☐ Yes ☐ No Steroids?
- ☐ Yes ☐ No Tobacco products?
- ☐ Yes ☐ No Recreational drugs?
- ☐ Yes ☐ No Alcohol consumption?

If you answered yes to any of the above questions, please explain:

____
____

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FITZPATRICK SKIN TYPE

Please answer each question below.

GENETIC DISPOSITION

Eye Color
- ☐ **0** Light colors
- ☐ **1** Blue, gray or green
- ☐ **2** Dark
- ☐ **3** Brown
- ☐ **4** Black

Natural Hair Color
- ☐ **0** Sandy red
- ☐ **1** Blonde
- ☐ **2** Chestnut or dark blonde
- ☐ **3** Brown
- ☐ **4** Black

Your Skin Color (unexposed areas)
- ☐ **0** Reddish
- ☐ **1** Pale
- ☐ **2** Beige or olive
- ☐ **3** Brown
- ☐ **4** Dark Brown

Freckles (unexposed areas)
- ☐ **0** Many
- ☐ **1** Several
- ☐ **2** Few
- ☐ **3** Rare
- ☐ **4** None

TANNING HABITS

How often do you tan?
- ☐ **0** Never
- ☐ **1** Seldom
- ☐ **2** Sometimes
- ☐ **3** Often
- ☐ **4** Always

When was your last tan?
- ☐ **0** +3 Months ago
- ☐ **1** 2-3 Months ago
- ☐ **2** 1-2 Months ago
- ☐ **3** Weeks ago
- ☐ **4** Days ago

REACTION TO SUN EXPOSURE

If you stay in the sun too long?
- ☐ **0** Painful blisters, peeling
- ☐ **1** Mild blisters, peeling
- ☐ **2** Burn, mild peeling
- ☐ **3** Rare
- ☐ **4** No burning

Do you turn brown?
- ☐ **0** Never
- ☐ **1** Seldom
- ☐ **2** Sometimes
- ☐ **3** Often
- ☐ **4** Always

How brown do you get?
- ☐ **0** Never
- ☐ **1** Light tan
- ☐ **2** Medium tan
- ☐ **3** Dark tan
- ☐ **4** Deep dark

Is your face sensitive to the sun?
- ☐ **0** Very sensitive
- ☐ **1** Sensitive
- ☐ **2** Sometimes
- ☐ **3** Resistant
- ☐ **4** Never had a problem

SCORE *(for office use)*

☐ **0-6 Skin Type I**
Always burns, never tans (pale white skin)

☐ **7-13 Skin Type II**
Always burns easily, tans minimally (white skin)

☐ **14-20 Skin Type III**
Burns moderately, tans uniformly (light brown skin)

☐ **21-27 Skin Type IV**
Burns minimally, always tans well (moderate brown skin)

☐ **28-34 Skin Type V**
Rarely burns, tans profusely (dark brown skin)

☐ **35+ Skin Type VI**
Never burns (deeply pigmented dark brown to black skin)

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PHOTOGRAPHIC AUTHORIZATION

I consent to the taking of photographs or videotapes of myself or parts of my body by IMAMI[MD] SKIN & COSMETIC CENTER AN AFFILIATE OF TEPAS HEALTHCARE (ISCC of TEPAS), or his designee, in connection with any and/or all plastic surgery procedure(s) to be performed by ISCC of TEPAS.

I understand that photographs may be required by my insurance company for the purpose of prior authorization and consent to the release of any requested images for this purpose.

I understand that such photographs, videotapes or case histories may be published by ISCC of TEPAS and/or any party acting under his license and authority in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from ISCC of TEPAS.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

I release and discharge ISCC of TEPAS and all parties acting under his license and authority from all rights that I may have in the photographs, videotapes or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

______________________________   /   /

Patient Signature   Date

____

Physician/Witness Signature

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PATIENT PARTNERSHIP PLAN

At the practice of IMAMI[MD] SKIN & COSMETIC CENTER AN AFFILIATE OF TEPAS HEALTHCARE (ISCC of TEPAS), your privacy is a very important part of our mission and plays a very big factor in your experience. Emran Imami, MD and staff adhere to the highest standards of respecting and protecting patient privacy and the confidentiality of your health care information. Additionally our team complies with all state and federal regulations regarding the privacy of individual health care information, including HIPPA (Health Care Insurance Privacy and Protection Act), enacted on April 14, 2003.

As of April 14th 2003, we are required by law to offer you a copy of the "Notice of Privacy Practices" regarding your Personal Health Information (PHI).

Your PHI, also known as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating heath professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

The "Notice of Privacy Practices" details the following:

- How we may use/disclose your PHI to carry out treatment, payment or health care operations.
- How you may request copies of your healthcare information.
- How you may verify the accuracy of this information.
- How you may request an accounting of certain external disclosures of your PHI.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Please acknowledge that you have been offered a "Notice of Privacy Practices" by signing below:

"I have been offered a Notice of Privacy Practices by ISCC of TEPAS and I fully understand and accept the terms of this consent."

______________________________   /   /

Signature: (Patient, Parent or Guardian)   Date