eden
SKIN & BODY INSTITUTE

MEDICAL HISTORY AND INTAKE BOOKLET

CLIENT INFORMATION

Client Name: _____ Client ID #: _____

Date of birth (mm/dd/yy): _____ / _____ / _____ Height: _____ Weight: _____

Address: _____ City: _____

State/Province: _____ Zip/Postal Code: _____ Country: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Can I leave a message at (circle one): Home Work Cell Email :_____

Health Card no (& version code): _____ Occupation: _____

Emergency Contact Name and Number: _____

Referred by: _____

MEDICAL HISTORY

There exists a risk if our staff is not aware of the general health and medical background of a client. This information may critically affect what procedure we may recommend or safely undertake. Please provide us with the following information and keep it updated

Please circle all of the following medical conditions you now have or have had in the past, if you have had none, please circle "None of the above:"

bleeding tendency / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / high blood pressure / pace maker / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / rheumatoid arthritis / scleroderma / lupus / porphyria / depression / mental illness / drug or alcohol addiction / hepatitis B / hepatitis C / HIV / contact lenses / loose or chipped teeth / dentures / dental implants / veneers / caps / None of the above / any other serious illness or injury please explain: _____

Please list all medications that you are currently taking or have used in the past 6 months. Use the back of page if necessary.

Medication(s): _____

Amount: _____ Frequency: _____

Please list all Naturopathic, Health Food Supplements and Vitamins:

_____

Please list all ALLERGIES including LATEX:

_____

Are you a smoker? (circle one): Yes No If you are an ex-smoker, for how long are you smoke free? _____

How much are (were) you smoking? _____ For how long? _____

How much alcohol do you drink per week? _____ Caffeine per week? _____

Is there any possibility that you may be pregnant at this time? (circle one): Yes No

Do you have a history of cold sores? (circle one): Yes No If yes, when was your last outbreak? _____

Do you or your family have a history of atypical moles, vitiligo, developing keloids, melanoma or skin cancer? (circle one): Yes No

If yes, please circle which and explain: _____

Please list all surgeries that you have had (include plastic surgery and wisdom teeth removal) with the date you had the surgery

_____

_____

Have you or anyone in your family ever had or have a history of unusual reactions or problems with LOCAL anesthesia (dental freezing),

TOPICAL anesthesia (anesthetic creams or gels) or GENERAL anesthesia (rashes, muscle weakness, jaundice, breathing problems or unexpected fevers(s))? (circle one): Yes No If yes, please explain:_____

Have you ever seen a cardiologist? (circle one): Yes No Physician Name: _____

Date of last EKG? _____

I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and psychological status. I, _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize a history examination by my doctor and such assistant or staff as may be assigned by him/her.

If appropriate, I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. I understand that photography is a necessary part of planning and evaluating cosmetic procedures. I authorize the taking of photographs at the direction of my physician or physician delegate and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential unless otherwise disclosed.

I understand that there is a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance

_____ _____

Patient or Person Authorized to Sign for Patient Please Print Name Here

DATE: _____ **RELATIONSHIP (circle one):** Patient Spouse Parent Guardian

PRIVACY POLICY & CONSENT

We collect personal health information about you directly from you and this personal health information may include, for example, your name, date of birth, address, email address, phone numbers, health history, records of your visits.

We may use and disclose your personal health information only to the extent necessary to:

- Treat and care for you
- Receive payment for your treatment and care (Credit Card information)
- Plan, administer and manage our internal operations
- Conduct quality improvement activities (such as sending patients satisfaction surveys) informational letters and coupon advertising
- Compile statistics **(this excludes the use of names, addresses, phone numbers and email addresses)**
- Comply with legal and regulatory requirements and fulfill other purposes permitted or required by law

We take steps to protect your personal health information from theft, loss and unauthorized access, copying, modification, use, disclosure and disposal. We conduct audits and complete investigations to monitor and manage our privacy compliance. We take steps to ensure that everyone who performs services for us protects your privacy and only uses your personal health information for the purposes you have consented to.

I, _____, have reviewed Jane Leigh Eden's Privacy Policy concerning the collection, use and disclosure of personal health information. I understand that Jane Leigh Eden is seeking my consent to collect, use and/or disclose my personal health information from me or from the person acting on my behalf for any or all of the purposes listed above. I understand that I can refuse to sign this consent form and that I can withdraw my consent at any time by writing to Jane Leigh Eden. I understand that refusal to sign this consent form or withdrawal of my consent may result in Jane Leigh Eden refusing to provide services to me.

I hereby authorize Jane Leigh Eden to collect, use and disclose my personal health information for the purposes listed above.

Name: _____:

Address: _____

Tel. Home: _____ **Tel. Work:** _____

Signature: _____ **Date:** _____