Capital Medical Group --CAPITAL AESTHETICS

Personal Profile and Health History

Name:____Home Phone:____________________________

Address:____Work Phone:____________________________

City/State/Zip: ____

Date of Birth: ___________________________________Age:_________Gender: M____F_____

Occupation: __________________________________ Email address:_____________________________

How did you hear about us? ____

What cosmetic/aesthetic procedures are you interested in?

____

____

Please share any questions, concerns or comments:____

Females: Are you pregnant? ❑ Yes ❑ No Are you breastfeeding? ❑ Yes ❑ No
Are you planning pregnancy during the course of your treatment? ❑ Yes ❑ No

Your genetic background affects your skin and its response to the laser. Please specify your ethnic origin:
❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Mediterranean
❑ Middle Eastern ❑Native American ❑ Other ________________________________

Please complete the following items of medical history. Please, always inform us of any change in your medical history and/or medications. Please list **all** medications including prescription and over the counter drugs, vitamins, herbs, supplements.

____

____

Are you allergic to any medications? ❑ Yes ❑ No Please list medications and reactions.____________

☐Acne	☐ High Blood Pressure	☐ Permanent Makeup
☐Bleeding Disorders	☐ Hirsutism	☐ Precocious Puberty
☐Burns/Skin Grafts	☐ Hormone Replacement Rx	☐ Psoriasis
☐Cold Sores/Fever Blisters	☐ Implants	☐ Seizures
☐Diabetes	☐ Kaposi's Sarcoma	☐ Shingles
☐Endocrine Disorders	☐ Keloid Scars	☐ Skin Cancer
☐Excessive Bleeding	☐ Liver Disease	☐ Tattoos
☐Gold Therapy	☐ Lupus Erythematosus	☐ Thyroid Disease
☐Heart Disease	☐ Mental Disease	☐ Vitiligo
☐Herpes	☐ Neuromuscular Disease	☐ Other _____________

Personal Profile and Health History

☐ Have you had surgery in the area to be treated? If "Yes", please explain

____

____

If the answer to any of the following questions is yes, please provide details in the space provided.

Are you currently being treated for any medical conditions?	Yes	No
Explain:____		
Do you smoke? If so # per day?__________________ _________________	Yes	No
Do you drink alcohol? Amount per day? ____________________________	Yes	No
Have you used Accutane in the last 6 months? How recently? __________	Yes	No
Do you have any active skin diseases or infection in the area to be treated?	Yes	No
Do you have any skin allergies?	Yes	No
Are you allergic to latex, lidocaine, or any lotions? Please circle any that apply	Yes	No
Are you currently using glycolic acid or Retin A? Please circle any that apply.	Yes	No
Have you had a chemical peel or facial within the last week?	Yes	No
What products are you currently using on your skin?		
Describe: ____		
Have you had any permanent cosmetic tattooing to the area to be treated?	Yes	No
Do you have any metal or other implants? Where? ___________________	Yes	No
Have you had any previous laser treatment or other skin treatment to the area to be treated? Describe: _______________________________________	Yes	No
Are there any moles with hair in the area to be treated?	Yes	No
Are you currently using or have used within the last six weeks a tanning bed or tanning cream? If yes, date of last use ___________________________	Yes	No
Have you been exposed to the sun within the last four to six weeks?	Yes	No
If yes, approximate date of last exposure _________________________		

Name of your family doctor: _____________________________ Phone No. _______________

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant has clarified any questions I did not understand.

Signature of Client: ____Date:_________________________

Signature of Dr./ARNP/PA _______________________________________ Date:_________________________

Capital Medical Group --- Capital Aesthetics
1001 Leawood Drive Suite A ◊ Frankfort, KY 40601 ◊ ph: 502.875.0872 fax: 502875.2387

FINANCIAL POLICY

Payment for Aesthetic Services is required at the time of service. These services are considered cosmetic in nature and therefore are not billable to health insurance plans.

Cancellations must be made 24 hours in advance of your appointment time. No shows or cancellations with less than 24 hours notice may result in a $25 charge.

Please expect to pay in full for the service on the day it is performed.

We accept

CASH

CHECKS

Most Major Credit Cards: Visa, Master Card, American Express, Discover

CareCredit: no interest and extended payment plans subject to credit approval.

I acknowledge that I have read the financial policy above and understand that I am responsible for payment for my services at the time of service.

____ Date:_____________

CAPITAL AESTHETICS- 1001 Leawood Drive Suite A Frankfort
KY 40601 502.875.0872 www.capmedgrp.com

JUVEDERM PATIENT INFORMED CONSENT TO TREAT

Patient Name:__________________________________ Date:______________________

Injectible Juvederm Ultra and Juvederm Ultra Plus Implants are gels of hyaluronic acid generated by non animal protein. There is no necessity for skin testing prior to receiving Juvederm treatment, as allergic reaction is very unlikely. Juvederm is indicated for implantation into the mid to deep dermal layers of the skin in order to temporarily provide correction of moderate to severe facial wrinkles and folds. Juvederm has been shown to provide correction to the injected sites fro up to 6 to 9 months; however, the correction does not last as long when used for lip augmentation. **Juvederm has not been studied for safety and effectiveness in any other anatomic regions other than naso-labial folds and is not FDA approved for any other sites other than nasal labial folds.** Juvederm should not be used by patients with severe allergies and with a history of anaphylaxis, pregnant or nursing, under the age of 18 in areas of active infection, or on immunosuppressive therapy.

The risks involved in receiving Juvederm injections include very temporary inflammation at injection site, demonstrated as redness, slight swelling, bruising, and tenderness and possibly itching. If laser treatment, chemical peeling or any other procedure based on active dermal response is considered after treatment, there is a possible rick of eliciting an inflammatory reaction at the implant site. Without touch up injections, the correction will subside gradually and your skin will look as it did before treatment. Patients using substances that reduce coagulation, such as aspirin and non-steroidal anti-inflammatory drugs may experience increased bleeding with resulting bruising at the injection sites. Other risks may include temporary local pain, redness, and itching, temporary skin discoloration, bruising and swelling in the treated area. Additional side effects are possible, but none have been observed or are known of at this time.

You should contact your healthcare provider immediately should any unusual side effects occur.

As with any injection procedure, there exists the risk of side effects. These risks have been explained to me in detail. I have read the above information and have had the procedure explained to me by my doctor or his representative. I understand the success of this procedure cannot be guaranteed and I am aware of the benefits and risks associated with this procedure. I give my consent to treatment with Juvederm by ____, or his/her representative:______________________ .

Patient Signature: ____

Date: ____

Witness Signature: ____

Date: ____

Health Care Provider: ____

Date: ____

CAPITAL MEDICAL GROUP
Family Heart Imaging Occupational Aesthetics

CAPITAL AESTHETICS- 1001 Leawood Drive Suite A Frankfort KY 40601 ◊ 502.875.0872
www.capmedgrp.com

USE OF PHOTOGRAPHS

EXPLANATION:

This consent form authorizes this clinic and individual members of the clinic's staff to use photographs of pre-treatment, post-treatment, and treatment in progress for the purposes of teaching, research and as illustrations of typical expected results. Under no circumstances will any publication or material bear any name or personal identifier. Your refusal to consent to use these photographs for purposes other than medical record documentation will in no way influence your treatment.

CONSENT:
I understand the photographs taken of me shall be used for documentation in my medical record and if in the judgment of the medical health care professional, medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in conjunction with each other. In professional journals or medical books, or used for any other purpose which my health care professional may deem proper in the interest of medical education, knowledge or research.

I waive the rights that I may have to any claims for payment or royalties in connection with any exhibition, televising or publication of these photographs.

I release and hold harmless the clinic, staff and consultants from any liability in connection with the use of such materials.

I understand that the foregoing consent is subject to the limitation: Under No circumstances will any such publication, film photograph, video or material exhibited contain my name unless voluntarily disclosed by me.

______________________________ ______________________________

Signature of Patient Signature of Witness

______________________________ ______________________________

Printed Name of Patient Printed Name of Witness

______________________________ ______________________________

Date Date