TEMECULA MED SPA

PATIENT REGISTRATION

Last Name: _____ First Name: _____ M.I. _____

Home Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

Date of Birth: _____ /_____ /_____ Age: _____ Sex: F M Marital Status: S M D W

Email: _____ Would you like to receive our monthly specials via email? Y N

How did you hear about us? Google Yelp Walk by 24Hr Fitness Facebook

If a Patient referred you, whom may we thank: _____

Do you have Aesthetic concerns or specific products you would like to discuss or get treatment for?

☐ Wrinkles ☐ Uneven skin tone ☐ Spots ☐ Skin texture ☐ Fine lines

☐ Unwanted Hair ☐ Unwanted Tattoo ☐ Scars ☐ Other _____

_____

MEDICAL HISTORY

How is your general health?_____ Are you pregnant or nursing? _____

(Check box if you've experienced any of the following)

☐ Bleeding excessively after **a cut, wound or injury**
☐ Fainting, dizziness
☐ Diabetes, insulin dependant
☐ Stroke, blood clot
☐ Heart disease
☐ Cancer, skin or general
☐ Fever blister or cold sores
☐ Allergies, please list _____

Please list current medications : _____

_____

Emergency Contact: _____Relationship to patient: _____

Phone: _____

FINANCIAL & CANCELLATION POLICY

FINANCIAL AND APPOINTMENT CANCELLATION POLICY

Payment is expected at time services are rendered. We DO NOT ACCEPT checks. We accept Cash, Visa, Discover, MasterCard, American Express, and Care Credit. If at any time you DO NOT cancel or reschedule your appointment within **twenty-four (24) hour**s prior to the appointment time, there will be a **$50.00 charge** to your account, for which you will be responsible for prior to your next procedure. I have read and understood the above statements. I agree to comply with the financial policies of the office and understand that I am financially responsible for my account.

I have read and understand the above policies and disclosures.

Signature _____ Date _____

Temecula Med Spa
Dennis K. Miller, DO

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEGEMENT

Patient Name _____ Date of birth _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

This practice is required by law to maintain the privacy of the protected health information and is required to abide by the terms of the notice currently in effect.
Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.

A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.

A description of uses and disclosures that are prohibited or materially limited by law, a description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.

My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.

The right to request restrictions on certain uses and disclosures of my protected health information, and this practice is not required to agree to a requested restriction.

The right to receive confidential communications of protected health information. The right to inspect and copy protected health information. The right to amend protected health information. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of the Notice of Private Practices from this
practice upon request.

This practice reserves the right to change the terms of its Notice of Private Practices and to make new provisions effective for all protected health information it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature _____ Date _____

Relationship to patient (if signed by person other than patient) _____

TEMECULA MED SPA

FITZPATRICK SKIN TYPE

The most commonly used scheme to classify a person's skin type by their response to sun exposure in terms of the degree of burning and tanning. Developed by Thomas B. Fitzpatrick*, MD, PhD.

Name _____ Date _____

Circle the number that pertains to you

Eye Color

Light colors	0
Blue, gray or green	1
Dark	2
Brown	3
Black	4

Freckles

(unexposed areas)

Many	0
Several	1
Few	2
Rare	3
None	4

Do you turn brown?

Never	0
Seldom	1
Sometimes	2
Often	3
Always	4

Natural hair color

Sandy red	0
Blond	1
Dark blonde	2
Brown	3
Black	4

If you stay in the sun too long?

Painful blisters	0
Peeling, mild blisters	1
Burn , mild peeling	2
Rare	3
No burning	4

How brown do you get?

No brown at all	0
Light tan	1
Chestnut/dK blond	2
Brown	3
Black	4

Your skin color

(unexposed areas)

Reddish	0
Pale	1
Beige/olive	2
Brown	3
Dark brown	4

How sensitive are you to the sun?

Very sensitive	0
Sensitive	1
Sometimes	2
Resistant	3
Never had a problem	4

When was your last tan?

0 to 3 months ago	0
2-3 months ago	1
1-2 months ago	2
3 weeks ago	3
4 Days	4

Add up results from above to determine your skin type

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

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

14-20 Skin Type III
Burns moderately,
Tans uniformly

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)