------------------------------------NEW PATIENT INTAKE INFORMATION----------------------------------

Name (First, Last) ________________________________, ______________________________ Date ___________________

Preferred Name: ____________________________

Address:____ Apartment #_____________

City:____ State:_______________________________ Zip:____________________

Marital Status (Circle): Single Married Widowed Divorced

Sex at Birth (Circle): Male Female

Birth Date:____________________ Age: _______

Gender (Circle): Male Female

Home Phone:(_______)_____________________

Cell Phone:(________)___________________

Email Address:____ How did you hear about us?__________________________________

Best method of contact to leave any confidential information regarding your treatment (please circle): Home Work Cell Email

What would you like to discuss with the Doctor today: ____

____

____

Primary Care Physician Name:_____________________________________ Phone Number:(_____)_________________________

Your Employer:____ Occupation:___________________________________

Emergency Contact Name:____________________________ Number:__________________ Relationship:____________________

Pharmacy Name:_____________________________________ Number:____

List all Surgeries (Hospitalization and the Date of Occurrence) and Current Illnesses or any Recent Accidents:

List the name of all <u>medications</u> you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency:

Do you have or have you had any of the following: (circle for each, provide date occurred if Yes)

Aids / HIV	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Arthritis	No	Yes	Fever Blisters	No	Yes	Rash / Allergic Skin Reaction	No	Yes
Asthma	No	Yes	Goiter / Thyroid	No	Yes	Sinus Problems / Infections	No	Yes
Autoimmune Disorder	No	Yes	Hay Fever / Allergies	No	Yes	Stroke	No	Yes
Bronchitis	No	Yes	Headaches / Migraine	No	Yes	Tonsillitis	No	Yes
Cancer	No	Yes	Heart Trouble	No	Yes	Tuberculosis	No	Yes
Depression	No	Yes	Hepatitis	No	Yes	Ulcers	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes			
Dizziness / Vertigo	No	Yes	Keloid Scaring	No	Yes			
Ear Infection	No	Yes	Kidney Problems	No	Yes			
Epilepsy / Seizures	No	Yes	Lupus	No	Yes			

DO YOU SMOKE? NO YES **DO YOU DRINK ALCOHOL? NO YES** **DO YOU USE RECREATIONAL DRUGS? NO YES**

List ALL drug, food allergies, and/or latex allergies:

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--HIPAA PATIENT CONSENT--

Shino Bay Cosmetic Dermatology & Laser Institute (SBCDLI) is committed to protecting the privacy of your medical information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that governs the use and disclosure of a person's health information. Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. The Notice contains a "Patient Rights" section describing your rights under the law. The following statements cover the basics of your rights as a patient under HIPAA:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- We have a "Notice of Privacy Practices" and you have the right to review a detailed copy of our Notice before signing this HIPAA Patient Consent.
- We reserve the right to change the terms of our "Notice of Privacy Practices".
- If we change our Notice, you may obtain a revised copy by contacting our office.
- You have the right to restrict the uses of your protected health information.
- You may revoke this HIPAA Consent in writing at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Additionally, It is the policy of SBCDLI, to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice. We may also send you other communications informing you of changes to office policy, new technology and specials that you might find valuable or informative. That said, contact would only come directly from us; We will never sell or trade your private information including phone numbers, e-mail address or home/work addresses.

By signing the next page of this document, you certify that you have read our HIPAA Patient Consent and have had the opportunity to review a more detailed version if so desired. Your signature also signifies that you agree with the above statements and this policy. You also agree to authorize the release of medical information to your primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. We provide this form and information in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

--------------------------------------FINANCIAL RESPONSIBILITY POLICY-----------------------------------

I understand that payment is required for all services rendered. I agree to pay any unmet deductible, non-covered services, and co-payment. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. SBCDLI, is not responsible for knowing my insurance plan, what it covers, or the deductible requirements. I understand that SBCDLI accepts payment in the form of cash, check, or credit card. In the event that my account must be turned over to collections, I understand that a **$100.00** collection fee will be added to my account balance. My printed name and signature below signifies my understanding and willingness to comply with this policy and to authorize payment of medical benefits to SBCDLI.

-------------------------------------MISSED / LATE APPOINTMENT POLICY--------------------------------

I understand that Dr. Aguilera strives to treat all patients at their scheduled times and that I must provide at least 24 hours notice if I need to reschedule or am unable to make my appointment. I understand that if I frequently miss appointments or am frequently late for appointments then a credit card may be required to book future appointments. I also understand that a deposit of **$50.00** will be required to book appointments for cosmetic services.

-------------------------------------CONSENT FOR PHOTOGRAPHY / VIDEO-------------------------------

I hereby consent to cosmetic and dermatology images and / or video being made of me or my child / dependant. These photos will be used as before and after documentation in the office. I agree that duplicates may be made for the referring doctor.

I agree that the images and results may be used for the following purposes:

- Electronically emailed to my treating health
- Used by Dr. Shino Bay Aguilera for education and training purposes
- Used in paper or electronic health publications
- Used by Dr. Shino Bay Aguilera for Advertising purposes (Marketing, Newspapers, TV, Magazines, etc.)
- Television and other media
- Display photos in the office
- Showing our patients

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------------------------CONSENT FOR ADDITIONAL TREATMENT / TOUCH-UP---------------------

At Shino Bay Cosmetic Dermatology and Laser Institute, we have invested in you. Our goal is to achieve the optimal result in the safest, fastest way with the least number of treatments necessary.

As everyone's individual body and chemistry differ, people often do respond differently to treatments. Your first session doing a new procedure may sometimes be the session where we find your ideal treatment protocol. Laser energy settings and aesthetic injectable amounts vary and we will customize what will best suit your needs. Once we know this, similar treatments will be standardized for your convenience.

Dr. Aguilera does not believe in treating at extremely high energy settings with laser treatments, nor does he believe in over injecting. His conservative approach and expertise leaves patients looking refreshed and rejuvenated without looking altered or overdone. We will strive to minimize the number of treatments required, so that you save time and money. Our main goal is to safely achieve your optimal results.

Many cosmetic procedures will take more than one session to safely achieve superlative, natural looking results, while others require just one treatment. Please be advised that additional treatment variations may be necessary.

I do understand that a follow-up / touch-up appointment may be necessary, and I will be billed at normal fees.

---------------------------CONSENT FOR EXAMINATION AND TREATMENT----------------------------

I hereby authorize Shino Bay Cosmetic Dermatology & Laser Institute, Dr. Shino Bay Aguilera, his associate(s), and/or his staff to examine me (or the patient named on this form) and to administer any and all treatment that the doctor or his associate(s) deem necessary.

My printed name & signature below certify that I have provided complete and accurate contact & medical information and that I have read, fully understand & completely agree with the HIPAA Patient Consent, Financial Responsibility Policy, Missed / Late Appointment Policy, Consent for Photography / Video, and Consent for Additional Treatment / Touch-up contained in this document and I agree to Examination and Treatment.

☐______________________________ **Printed Name of Patient (or legal guardian)** ☐______________________________ **Signature of Patient (or legal guardian)**	☐________________________ **Date**

Are you a member of Allergan's Brilliant Distinctions Program? If not, please ask the front desk how to sign up. If you are a member, please advise the front desk you are a member so we will be sure to award you points or redeem your coupons.

Fitzpatrick Skin Type Quiz

Name: ________________________________ Date: ______________________

This information will help our office better evaluate your skin type so treatments will be more effective. Skin type is often categorized according to the Fitzpatrick skin type scale, which ranges from very fair (skin type 1) to very dark (skin type 6).
By using the information you provide on this form, we can be better prepared to provide you with the best care.
Please take a few minutes to fill out this questionnaire. Circle each answer and total each table.

Genetic Disposition:

Score	0	1	2	3	4
Your eye color?	Light Blue, Gray	Blue, Gray or Green	Blue	Dark Brown	Brownish Black
Natural color of hair?	Sandy, Red	Blonde	Chestnut/Dark Blonde	Dark Brown	Black
Color of non-exposed skin	Reddish	Very Pale	Pale w/BeigeTint	Light Brown	Dark Brown
Do you have freckles on unexposed area?	Many	Several	Few	Incidental	None

Total score for genetic disposition: __________

Reaction to Sun Exposure:

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely burns	Never Burns
To What degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tans easily	Turns dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Vern Sensitive	Sensitive	Normal	Very resistant	Never had a problem

Total score for reaction to sun exposure: __________

Tanning Habits:

Score	0	1	2	3	4
When did you last expose your body to sun or tanning both/cream?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than one month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Other	Always

Total score for tanning habits: __________

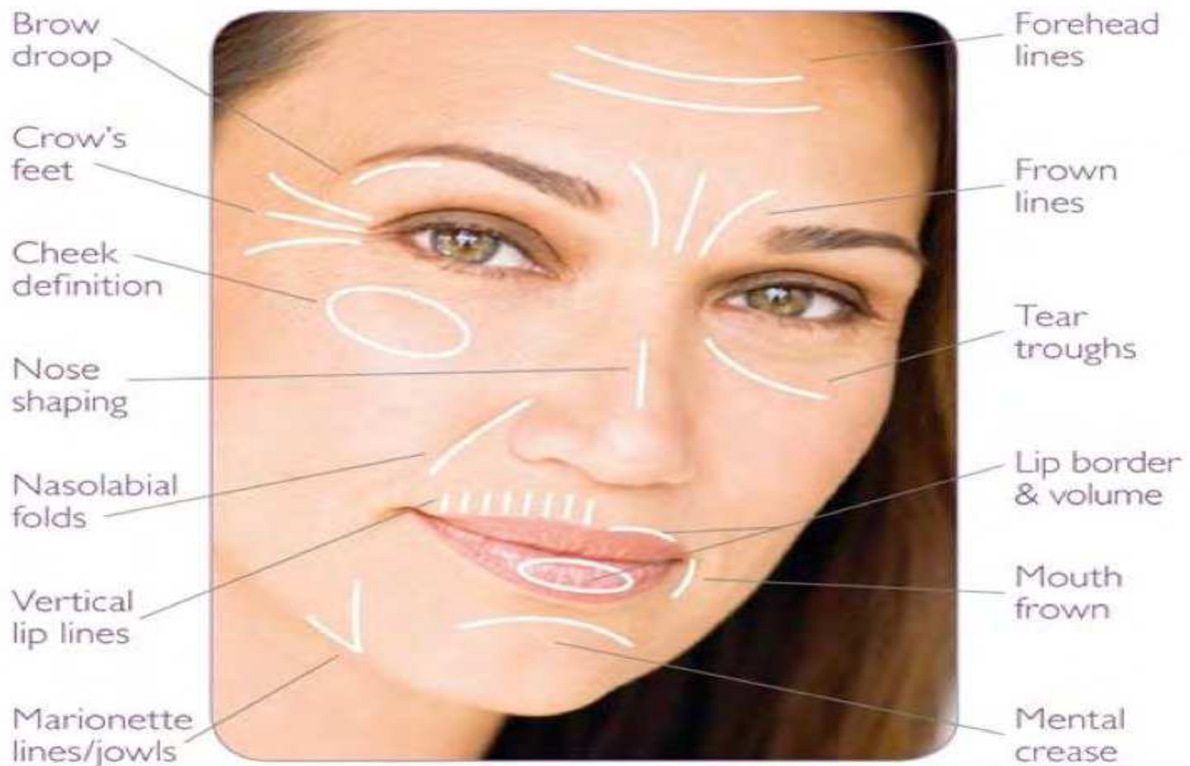
Summary: Add up the total scores for each section for your skin type score to give you a better evaluation of your skin type.
_______ Total score for Genetic Disposition
_______ Total score for Reaction to Sun-Exposure
_______ Total score for Tanning Habits ____________________ **SKIN TYPE SCORE**

Your Fitzpatrick skin type:

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V-VI

Ethnic background is of importance when considering skin color and laser hair removal. If known what is your ethnic background? ____

PLEASE TELL US ABOUT YOUR FACE



With respect to facial aesthetics, please highlight those areas of your face that bothers or concerns you. Please circle the areas that concern you and rate from 1-5.

1 = least concerned **5 = most concerned**

Additional information or concerns you would like to discuss: ____________________

____

____

____

____

____

Approval to send information via email or mail to:

email address: ________________________ ______________________________

Signature

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AESTHETIC INTEREST QUESTIONNAIRE		
Please complete this questionnaire to help us better understand your aesthetic needs and concerns. During your consultation, your respones will help us identify ideal treatment options.		
NAME:	DATE	
What is the main reason you are here for this consultaions?		
What aesthetic treatments and procedures, if any, have you had in the past?		
If you have previously had any aesthetic treatments or procedures, were you pleased with the outcome? If no, in what way(s) were your dissatisfied?	◯ Yes	◯ No
Do you feel like you look older than you really are?	◯ Yes	◯ No
Do you have any concerns about wrinkles or fine lines?	◯ Yes	◯ No
Are you happy with the size, shape and volume of your lips?	◯ Yes	◯ No
Do you have any concerns about sun damage or age spots?	◯ Yes	◯ No
Do you have any concerns about the apperance of your skin?	◯ Yes	◯ No
Do you want to learn more about at-home skin care?	◯ Yes	◯ No

Aesthetic Products, Treatments and Procedures

Check all that you are interested in:

◯ Botox/Dysport/Xeomin	◯ Skin Tightening Procedures
◯ Dermal Filler/Wrinkle filler	◯ Fat Reduction Procedures
◯ Professional Skin Care Products	◯Aesthetician Services
◯ Lip Treatments	◯ Laser Treatments
◯ Surgical Procedures	◯ Permanent Make-Up
◯ Laser Hair Removal	◯ Skin Rejuvenation