Please fill out this questionnaire prior to your office visit and email it back to us at: info@424cd.com or bring with you. If you have any questions for concerns please call us at: 858.204.0529

424 | cosmetic dermatology

Name:_____ Age: _____ Date of Birth: _____/_____/_____ Gender: M F

Address:_____ City:_____State:_____ZIP:_____

Phone: Home:_____Work:_____Cell:_____

Email:_____ Whom may we thank for referring you?:_____

In case of emergency whom may we contact?:_____Phone:_____

Medical History

☐ Heart disease
☐ Heart attack or chest pain
☐ Hypertension
☐ Heart pacemaker or defibrillator
☐ Diabetes
☐ Easy bleeding or bruising
☐ Delayed or abnormal wound healing
☐ Hepatitis
☐ Eye conditions
☐ HIV or AIDS
☐ Endocrine or hormone disorder
☐ Current or recent pregnancy

List any active medical problems you have:_____

List any medication you currently take:_____

List any medication allergies you have:_____

Are you allergic to any metals?_____Are you allergic to latex?_____ Do you use tobacco products?_____

Surgical History

List any operations you have had:

1._____ **3.**_____ **5.**_____

2._____ **4.**_____ **6.**_____

Dermatology History

☐ Chronic skin condition
☐ Photosensitivity
☐ Keloid or hypertrophic scar
☐ Pigmentation disorder
☐ Recent waxing or plucking
☐ Skin cancer
☐ Herpes simplex or cold sores
☐ Accutane use for acne
☐ Tetracycline use for acne
☐ Electrolysis or threading
☐ Laser skin resurfacing
☐ Chemical peel
☐ Botox® injection
☐ injection of collagen or other derma filter
☐ Recent sunburn or tan (including tanning bed)

What is your ethnic background? _____

When exposed to sun, do you usually: ☐ Always burn, never tan ☐ Burn easily, tan poorly ☐ Tan after initial burn

☐ Burn minimal, tan easily ☐ I Rarely burn, tan darkly easily ☐ Never Burn, always tan darkly

Do you use sunscreen regularly?:_____Do you use artificial or "sunless" tanning products?:_____

List any special skin care products you use:_____

Patients Signature:_____Date:_____

Parent or guardian (If patient is under 18 years of age):_____

Provider:_____Date:_____

Authorization for and Release of Medical Photographs/Slides/Videotapes

Cosmetic dermatology is a visually oriented specialty. As such, it is necessary that medical photographs be taken before, during and after a cosmetic procedure or treatment. This allows for you to see the before and after effects of the procedure. Photographs are required only for the body part in question. This means that unless the planned treatment is on the face or head itself the images typically do not include the face. Consent is required to take such images.

Additionally, patients may consent to release these medical photographs/slides, videotapes for a stated purpose such as for use in instructional, educational, or promotional materials. These materials are very important to insure continued understanding of the treatments available to all patients. Please read carefully the information contained in both sections below, and provide your consent where applicable.

A signature in Section 1 is required to receive your care at 424 cosmetic Dermatology; a signature in Section 2, while encouraged, is optional.

1. Consent to Take Photographs/Slides/Videotapes

I hereby authorize Nellie Blunt, PA-C, of 424 Cosmetic Dermatology, and/or her associates or licensees to take pre-procedural, procedural, and post-procedural photographs, slides, and/or videotapes.

I consent to the use of these images for the purposes of pre-procedural planning and post-procedural evaluation by Nellie Blunt, PA-C, and/or the staff at 424 Cosmetic Dermatology, and I understand that they shall be made a part of my medical record.

Patient Signature:_____Date:_____

Parent or Guardian (if patient is under 18 years of age):_____

Witness:_____

2. Consent for Release of Photographs/Slides/Videotapes

I hereby authorize Nellie Blunt, PA-C, of 424 Cosmetic Dermatology, and/or her associates or licensees to use pre-procedural, procedural, and post-procedural photographs, slides, and/or videotapes for professional medical or promotional purposes as deemed appropriate by them including but not limited to display of these images on public or commercial television, electronic digital networks scientific medical publications, lay publications, or during lectures to medical or lay groups for the purposes of informing the medical community or the general public about cosmetic dermatology and skin rejuvenation procedures available at 424 Cosmetic Dermatology.

Neither I nor any member of my family will be identified by name at any time. Unless it is necessary to include it, my face will not appear in the images. I understand that in some instances the images may portray features which could make my identity recognizable.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and I hereby grant this consent as a voluntary contribution in the interest of medical education. This permission may be rescinded by me at any time to prohibit future use by direct written communication with Nellie Blunt, PA-C, or 424 Cosmetic Dermatology.

Patient Signature:_____Date:_____

Parent or Guardian (if patient is under 18 years of age):_____

Witness:_____

Physician-Patient Arbitration Agreement

Article 1: *Agreement to Arbitrator:* It is understood that any disputes as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered will be determined by submission to arbitration as provided by CALIFORNIA LAW, and not by a lawsuit or resort to court process except as CALIFORNIA LAW provides for judicial review or arbitration proceedings. Both parties to this contract by entering into it are giving up constitutional rights to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

Article 2: *All Claims must be Arbitrated:* It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence-giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Article 3: *Procedures and Applicable Law:* A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators, appointed by the parties within thirty days of the demand of a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of the judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant any other applicable statutory or common law.

Each party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joiner in this arbitration or any person or entity which otherwise be a proper additional party in a court action, and upon such intervention and joiner any existing court action against such additional person entity shall be stayed pending arbitration.

The parties agree that provisions of CALIFORNIA LAW, applicable to heath care providers shall apply to disputes within this arbitration agreement, including but not limited to, Code of Civil Procedures Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, disposition may be taken without prior approval of the neutral arbitrator.

Article 4: *General Provisions*: All claims based upon the same incident, transaction of related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provide for the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: *Revocation:* This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the latent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: *Retroactive Effect:* If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below: _____

If any provisions of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be effected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Client Name (Print)_____Date:_____

Client Signature_____

Physician Representatives: Nellie Blunt, PA-C Signature_____

Cancellation and no Show Policy

A missed appointment is a loss to everyone, and timely cancellations create opportunities for other patients.

We understand unexpected circumstances may arise. If in the event something does arise, please contact us immediately to alert our staff and special arrangements will be made.

424 Cosmetic Dermatology does require 24-hour notice to cancel or reschedule your appointment.

Cancellations made in less than 24-hours and same day no shows will be subject to a $50 non-refundable fee.

I have read and understand the 414 Cosmetic Dermatology Cancellation and No Show Policy and I agree to honor this policy.

We are grateful for your cooperation.

Your 424 Cosmetic Dermatology Staff

Patient Signature_____Date_____

Patient Name (Print)_____

Acknowledgement of receipt of notice of privacy practices

I hereby acknowledge that I received a copy of the 424 Cosmetic Dermatology Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Patient Signature_____Date_____

Patient Name (Print)_____

If not signed by the patient, please indicate relationship:

_____Parent or Guardian of minor patient

_____Guardian or Conservator of an incompetent person

_____Beneficiary or Personal Representative of deceased patient