FACIAL 32
DENTAL ESTHETICS

Confidential Skin Health Questionnaire

Please Print

First Name _____Last Name _____ Date of Birth ____/____/_____
Street _____ Apt. # _____ City _____ State _____ Zip _____
Home ( ) _____ Mobile ( ) _____
Dermatologist/physician _____ Phone ( ) _____
Emergency Contact _____ Phone ( ) _____
Your occupation _____
E-Mail _____
Referred by ☐ Friend ☐ Drive-by ☐ Gift Certificate ☐ Drive by ☐ Google ☐ Facebook ☐ Other_____

1. What is the reason for your visit today? _____
2. What specific areas of concern do you have? _____

EXPECTATIONS and HISTORY

3. Which conditions would you like to improve?

☐ Acne Scarring ☐ Hyperpigmentation ☐ Fine Lines/ Wrinkles ☐ Enlarged Pores
☐ Acne ☐ Broken Capillaries ☐ Surgical/ Facial Scars ☐ Other _____
☐ Age Spots ☐ Stretch Marks

4.Have you ever had facial treatment in the past? ☐ Yes ☐ No
5. What was your experience? _____
6. How would you describe your skin?

☐ Normal ☐ Combination ☐ Oily ☐ Dry ☐ Sensitive ☐ Sun Damaged

7.How would you rate your skin? (Check one)

☐ Always burns, never tans ☐ Seldom burn – Always tans well ☐ Burns moderately – tans gradually
☐ Always burns easily, tans slightly ☐ Rarely burns – Deep tan ☐ Never burns – Deeply pigmented

8. Do you ever experience ☐ Flakiness ☐ Redness ☐ Tightness ☐ Excessive oily shine during the day?
9. What is your present skin regimen?

☐ Soap & water only ☐ Cleanser ☐ Toner ☐ Masque
☐ Moisturizer ☐ Exfoliation ☐ Sun Block Every Day

10. Are you ever exposed to chemicals, oils, or other caustic substances that may aggravate your skin? ☐ Yes ☐ No
If yes, what are they? _____
11. Do you blush easily? ☐ Yes ☐ No
If yes, what are the contributing factors? ☐ Emotions ☐ Foods ☐ Temperature Changes ☐ Other _____

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12. Do you ☐ Sunbathe? ☐ Use a tanning bed? ☐ How often? _____
13. Have you ever had

☐ Peels? ☐ Microdermabrasion? ☐ Facial Surgery? ☐ Cosmetic Surgery?

☐ Botox? ☐ Collagen Injections? ☐ Laser Resurfacing?

How recently? _____

14. Are you under treatment for any current skin condition? ☐ Yes ☐ No
If yes, what? _____

15. Does your skin heal ☐ Fast? ☐ Scars? ☐ Pigments?

16. Do you bruise easily? ☐ Yes ☐ No

17. Do you get sores/ blisters (Herpes Zoster/ Shingles)? ☐ Yes ☐ No

18. What medication/ hormone replacement/ vitamins do you presently take? _____
_____

19. Have you ever used

☐ Accutane ☐ Retin-A ☐ Renova ☐ Topical Antibiotics

☐ Differin ☐ Tazarac ☐ Hydroquinone ☐ Alpha Hydroxy Acids?

If yes, when and for how long? _____

20. Any personal or family history of skin cancer? ☐ Yes ☐ No
Provide Detail: _____

21. How would you describe your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

22. Have you had any of the following, past or present?

Acne	☐ Yes	☐ No	When_____
Allergies	☐ Yes	☐ No	
Arthritis or Bursitis	☐ Yes	☐ No	
Blood Pressure	☐ High	☐ Low	☐ Normal
Brest Implant	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Cataracts	☐ Yes	☐ No	
Cholesterol	☐ High	☐ Low	☐ Normal
Claustrophobic	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Diarrhea/Constipation	☐ Yes	☐ No	
Eczema	☐ Yes	☐ No	Where_____
Epilepsy	☐ Yes	☐ No	
Hay Fever	☐ Yes	☐ No	
Headaches	☐ Yes	☐ NO	How Often_____

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Heart Disease/ Conditions	☐ Yes	☐ No	Explain_____
Hepatitis	☐ Yes	☐ No	
HIV/AIDS	☐ Yes	☐ No	
Infections	☐ Yes	☐ No	
Lupus	☐ Yes	☐ No	
Menopausal	☐ Yes	☐ No	
Metal Implants	☐ Yes	☐ No	
Pacemaker	☐ Yes	☐ No	
Phlebitis	☐ Yes	☐ No	
Serious Injury	☐ Yes	☐ No	Explain_____
Sleep Problems	☐ Yes	☐ No	
Thyroid	☐ High	☐ Low	☐ Normal
Varicose Veins	☐ Yes	☐ No	
Do You Smoke?	☐ Yes	☐ No	
Do you wear contact lenses?	☐ Yes	☐ No	
Joint Replacement	☐ Yes	☐ No	
Pre-Medication	☐ Yes	☐ No	

23. Have you ever had a reaction to

☐ Cosmetics ☐ Metals ☐ Medication ☐ Food

☐ Fragrance ☐ Airborne Particles ☐ Other Explain

24. **For Women:**

Oral Contraception?	☐ Yes	☐ No
Are you pregnant or trying to get pregnant?	☐ Yes	☐ No
Are you taking hormone replacement?	☐ Yes	☐ No
Do you experience hormone imbalances?	☐ Yes	☐ No

25. For Men:

Do you shave with	☐ Electric Shaver?	☐ Razor
Do you experience skin breakouts?	☐ Yes	☐ No
Do you have ingrown hair?	☐ Yes	☐ No

Lifestyle & Diet

1. Is your stress level	☐ High	☐ Medium	☐ Low
2. Do you normally sleep well?	☐ Yes	☐ No	
3. Do you regularly exercise?	☐ Yes	☐ No	
4. Do you have food intolerances?	☐ Yes	☐ No	Explain: _____
5. Do you follow any special diet?	☐ Yes	☐ No	

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6. How many glasses of water do you consume daily? _____

7. How many cups of caffeine-type beverage (coffee, tea, soft drinks) do you consume daily?) ☐ 1-3 cups ☐ 4 or more

8. In our treatment program, it may be necessary to recommend alterations to or additions in your home care regimen; Would that be OK with you? ☐ Yes ☐ No

Your practitioner will recommend the appropriate schedule for future facial treatments or physician referral in order to achieve your skin improvement goals.

Informed Consent Release

I, _____, do fully understand all the questions above and have answered them all correctly and honestly. I understand that the services offered are not a substitute for medical care. I understand that the skin care professional will completely inform me of what to expect in the course of treatment and will recommend adjustments to my regimen if deemed necessary. I also am aware that individual results are dependent upon my age, skin condition, and lifestyle. I agree to actively participate in following appointment schedules and home care procedures to the best of my ability, so that I may obtain maximum effectiveness. In the even that I may have additional questions or concerns regarding my treatment or suggested home product routine, I will inform my skin care professional immediately.

I release and hold harmless the skin care professional [insert your name], [insert business name], and the staff harmless from any liability for adverse reactions that may result from this treatment.

POLICIES

1. We require **48-hours' notice** for cancellations. Cancellation for Monday must be phoned in on the Friday before.
2. If you are not satisfied with your service or products, please contact your skin care professional within 24- hours after your appointment so that the situation may be corrected. It is our policy to provide you with the best professional service and products customized for your skin condition.

I have read and understood all the foregoing information,

Patient Signature: _____ Date: _____

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Appointment Cancellation Policy

To Provide you with the best service possible, we need your cooperation in keeping appointments. Your appointment time has been reserved exclusively for you, and any changes affect many other patients. When it is necessary to change an appointment, we require a minimum **24-hour notice**, making it possible for another patient to use that scheduled time. If we are not given 24-hour notice, an **Appointment Cancellation** fee will be charged.

Our Policy is as follows:
The first time you break an appointment without proper notification, we will waive the charge as a courtesy. For any further missed appointments or cancellations made less than a 24-hour notice, there will be a charge of $50.00 billed to your account. This fee must be paid prior to your next appointment; this fee cannot be billed to your insurance company and will be your direct responsibility. After the third missed appointment, we will need a prepayment for any future appointments. We understand unforeseen circumstances arise, and we will take your situation into consideration. We realize accidents happen, family member gets sick, and emergencies occur. We will do our best to accommodate these rare occasions with grace, but please remember we track these occurrences as to prevent abuse of the policy.

Thank you for your cooperation and understanding in this matter. The policy exists to maintain our service expectations and to respect all of our patients' and team's time. We appreciate your help in continuing to provide you with the best possible dental care. If you have any questions or concerns regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

I, _____ (print name), have received a copy of Facial 32 Dental Esthetic's Appointment Cancellation Policy.

Signature: _____ Date: _____

Financial Policy

At Facial 32 Dental Esthetics, we believe that you deserve the best Healthcare available. As a cutting-edge dental practice, we provide the most current dental and facial technology to our patients. In order for our office to consistently provide these services, it is necessary for you to understand your financial responsibilities.
At the time of service, you will be financially responsible for paying for the services provided.
By understanding this financial policy, you will allow us to focus on your optimal health. We request a deposit of 25% down when scheduling for the first appointment so we can hold your appointment slot just for you.

We accept Cash, Check, Visa, MasterCard, Discover or American Express

Thank you for your cooperation.
Your signature below confirms that you have read out policy and will abide by it.
Patient: _____

Parent (or Guardian) Signature: _____
Date: _____

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information. I understand that information supplied by me, or my representatives, can and will only be used to:

* Conduct, plan and direct my dental treatment and for follow-up among multiple health care providers that may be involved in my treatment either directly or in-directly.
* Obtain payment or information from my dental insurance company. This includes verifying benefits and claim status.
* Call any number provided by patient to confirm appointments. This will also include mailing, emailing, or texting reminders for my next appointment.
* Conduct normal business operations.

I have received, read, and understand your Notice of Privacy Practices containing a more detailed explanation of the uses and disclosures of my protected health information. I understand that Facial 32 Dental Esthetics, L.L.C. has the right to change it Notice of Privacy Practices from time to time, and that I am entitled to receive a copy at any time by their office at 717-316-0733.

I also understand that I may request in writing that Facial 32 Dental Esthetics, L.L.C. restrict how my protected health information is used or disclosed to carry out my dental treatment, obtain payment or health care operating. I understand that Facial 32 Dental Esthetics, L.L.C. is not required to agree to my request. However, if they do, they are required by law to abide by my restrictions.

By signing below, I acknowledge receipt of the Notice of Privacy Practices and give my consent to use my protected health information supplied to this office in the way listed above. I understand that any other disclosures besides what is listed above require signed authorization.

Do you authorize us to leave detailed messages at your home and/or on your voicemail? Yes No
With whom do you authorize us to speak concerning treatment? _____
Their relationship to you, the patient _____
I have reviewed, understood and agreed to the content of the notice of privacy.

Patient Name: _____
Signature of Patient or Guardian: _____
Date: _____

There is no expiration of this form unless otherwise noted by the patient.

Office Use Only

I attempted to obtain the patient's signature in acknowledgement to the Notice of Privacy Practices notice but was unable to do so as stated below.

Date: _____ Initials: _____ Reason: _____
_____