EXCELIN MEDICAL Spa
The Art of Healthy Skin

5601 W. Grande Market Drive, Suite A | Appleton, WI 54913
Phone: 920-931-0022 | ExcelinMedicalSpa.com

Client Intake Form – Medical History

Full Name:_______________________________ Date of Birth: ______________

Address:_______________________________ City:______________ State:______ Zip:________

Mobile phone:______________ Home phone:______________ Work phone: ______________

Email address:_______________________________ Occupation:______________

Emergency contact name and phone number: _______________________________

How did you hear about us? _______________________________ Receive our Newsletter?________

Medical history:

1. Are you currently taking medication or supplements? ☐ Yes ☐ No If yes, what? ______________
2. Are you currently under the care of a physician? ☐ Yes ☐ No If yes, for what?______________
3. Do you have any of the following?

☐ Any active infection
☐ Bleeding disorders
☐ Bruising easily
☐ Dark spots of pregnancy
☐ Diabetes
☐ Pace Maker
☐ Epilepsy or seizures
☐ Hepatitis
☐ Herpes simplex
☐ High blood pressure
☐ Hormone imbalance
☐ Other____________
☐
☐ HIV / AIDS MRSA
☐ Skin cancer or moles
☐ Skin injury
☐ Vision deficits

4. Do you have allergies to any of the following? (check all that apply)

☐ medications ☐ latex ☐ food ☐ plants ☐ anesthesia ☐ other______________

Please list allergies: _______________________________

5. Do you take any of the following?

☐ Accutane (isotretinoin)
☐ Antibiotics
☐ Anti-coagulants
☐ Anti-depressants
☐ Suppressants
☐ Aspirin or Ibuprofen
☐ Cortisone or steroids
☐ Hormone/contraceptives
☐ Insulin
☐ Sedatives
☐ Thyroid medication
☐ Other______________

Questions about skin:

1. What topical skin medications or products are you currently using?______________
2. Have you used the following hair removal methods in the past 6 weeks? ☐ shaving ☐ waxing ☐ electrolysis
☐ plucking/tweezing ☐ threading ☐ depilatories
3. Do you form thick or raised scars (keloids) from cuts or burns? ☐ Yes ☐ No
4. Do you experience hyperpigmentation (redness/brown) from burns, cuts, or insect bites? ☐ Yes ☐ No
5. Have you ever had cold sores or fever blisters? ☐ Yes ☐ No
6. Have you ever had reactions to skin care products? ☐ Yes ☐ No If yes, what? ______________
7. When were you last exposed to the sun or tanning booth? ______________
8. Do you use self-tanners? ☐ Yes ☐ No
9. Are you planning a vacation in the sun? ☐ Yes ☐ No If so, when? ______________

Personal history:

1. Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?__________
2. What is your daily consumption of alcohol?______________
3. Do you wear contact lenses? ☐ Yes ☐ No

For female patients: Are you pregnant, trying to become pregnant, or breastfeeding? ☐ Yes ☐ No

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Signature:_______________________________ **Date:** ______________

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

____ ______________________________

Patient Name (PLEASE PRINT) **Date of Birth**

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" (the "Notice") of Forefront Dermatology, S.C., d/b/a Excelin Medical Spa. Our Notice provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by contacting our practice at 855-535-7175.

Please note that Forefront Dermatology may communicate with you in the following ways, unless you instruct us otherwise:

- In Forefront Dermatology's discretion, a confidential message may be left on your voicemail or answering machine at the preferred number(s) indicated below or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such message may include, without limitation, reminders of upcoming scheduled appointments information regarding your pathology or laboratory tests, billing information or answers to medical questions you may have inquired about to our staff.

Preferred Number ____________________	☐ Mobile (cell) ☐ Work ☐ Home
Preferred Number ____________________	☐ Mobile (cell) ☐ Work ☐ Home
Preferred Email Address ____________________	

- Forefront Dermatology may also communicate with you via e-mail, text message, or post card to your home address provided such method complies with applicable HIPAA communication standards.
- **Unless you check below**, you specifically authorize and give your express consent to receive autodialed and/or pre-recorded calls—including, but not limited to, voice and short message service (SMS) text messages and other electronic messages—from or on behalf of Forefront Dermatology and its representatives at the residential or cellular telephone number provided above or an appropriate e-mail address, not only in order to communicate appointment reminders, and notifications regarding the availability of pathology or laboratory results, but also for marketing or advertising messages offering products or services that may be of interest to you. Forefront Dermatology may receive direct or indirect payment for these marketing or advertising messages. You understand that by providing your telephone number and/or e-mail address to Forefront Dermatology, you consent to being contacted using the above-described methods. You understand that you are not required to sign this agreement in order to receive treatment. You further understand that you are not required to give this consent and that your consent is not a condition of purchasing or using any services offered by Forefront Dermatology.

  Marketing Related Opt-Out: *(Check all that apply)* ☐ Do Not Text ☐ Do Not Email

- If you have any questions about our Notice, please contact our compliance department – Phone: 920-663-0505, e-mail: compliance@forefrontderm.com

I acknowledge receipt of Forefront Dermatology's Notice of Privacy Practices. I understand and agree to how Forefront Dermatology may communicate with me, as stated above.

X____ ______________________________

(Signature of Patient or Legal Representative) **Date**

Parents may not sign for children over the age of 18.

If signed by someone other than patient, indicate relationship: ______________________________

Print name ______________________________

(Legal representative)

For Office Use Only

Complete this section if this form is not signed and dated by the patient or patient's representative.

Reasons why the acknowledgement was not obtained:

☐ Patient refused to sign this Acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.

☐ Other ______________________________

______________________________ ______________________________

Employee Name Date

Cancellation and No Show Policy

We strive to make your Excelin Medical Spa experience as positive as possible. Streamlining appointment schedules is an important part of your overall visit. We schedule appointments so that each patient receives the appropriate amount of time to be treated by our providers.

If you are unable to keep your appointment, please contact Excelin Medical Spa at 920-931-0022 at a minimum of 48 hours before your appointment time.

No show clients will be charged $50 for the missed appointment.

A $50 fee may be assessed to clients who cancel or reschedule their appointments less than 48 hours prior to their appointment.

I understand the cancellation and no show policy at Excelin Medical Spa and agree to these terms. Please sign and date on the line below.

Print name____Date___________

Sign Name____

We thank you for your continued trust and support and we look forward to seeing you at your next appointment.

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Patient Communication & Financial Policies for Cosmetic Patients

The Following are internal policies set in place by the administration of Forefront Dermatology S.C., d/b/a Excelin Medical Spa ("Forefront"). Signature is required before services can be provided.

Patient Communications: Confidential messages may be left on your voicemail or answering machine at the preferred number(s) you have provided to Forefront or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such message may include, without limitation, reminders of upcoming scheduled appointments information regarding your pathology or laboratory tests, billing information, or answers to medical questions you may have inquired about to our staff. Forefront may also communicate with you via e-mail, text message, or post card to your home address provided such method complies with applicable HIPAA communication standards. You understand that you are not required to agree to this provision in order to receive treatment.

Research: I authorize Forefront to contact me regarding any research study in which I may be eligible to participate relating to my care.

Non-sufficient Funds: A $35.00 charge will be added for any non-sufficient funds notice from the bank. If your account is sent to collections and we have to litigate in court, your visit/s with our office may become a matter of public record.

Cosmetic Procedures: Payment for a cosmetic procedure is due in full prior to treatment. There are no returns on cosmetic products sold unless such products are defective or, in the opinion of your provider, caused an adverse reaction.

Procedure Pricing: I understand that procedure estimates are only provided in writing. Written estimates must be requested prior to the appointment.

X ____

Signature of Patient

_____/___/________

Date

Updated 10/18/2019