PREMIER VEIN & BODY by SCHWARTZ

Thank you for choosing Premier Vein & Body and the office of Dr. Craig Schwartz. In order for us to fully understand your needs, we greatly appreciate your taking a moment to answer the following questions about your health and habits. All information will be held in strictest confidence.

Patient Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Male/Female/Non-Binary Preferred Pronoun: _____

Address: _____ City: _____

State: _____ Zip: _____

Cell #: _____ Home #: _____ Work #: _____

Email: _____ Preferred method of contact: _____

Can leave a message at: Home: _____ Work: _____ Cell: _____ Email: _____

Employer: _____ Occupation: _____

Emergency Contact Name & Number: _____

Height: _____ Weight: _____ Are you pregnant or trying? Y / N

Do you drink Alcoholic beverages? Y / N *If yes, how frequently:* _____

Do you Smoke? Y / N *If yes, how frequently* _____

How much water do you drink daily? _____

Family Doctor: _____

Pharmacy Name & Number: _____

How were you referred to the office-

_____ GOOGLE _____ WEBSITE _____FACEBOOK _____REALSELF _____INSTAGRAM

DR: _____ OTHER: _____

Do you take any medication?

_____Aspirin _____Anti-coagulants (blood thinners)

_____Hormones/contraceptives _____Appetite depressant (diet pills)

_____Thyroid medication _____Insulin

_____Sedatives _____Tranquilizers

_____Cortisone _____Retinol/Retin-A

_____Other (please specify): _____

Have you had a history of cold sores or fever blisters? Yes / No

If so, how often do you tend to break out? _____

Do you have a history of keloid scarring? Yes / No

Please list all surgeries that you have had (include plastic surgery and wisdom teeth removal) with the date you had the surgery:_____

_____

_____

Procedures or products of interest to you: (Check all that apply)

FACIAL/SKIN REJUVENATION:

_____Acne Treatment

_____Opus Plasma Skin Resurfacing

_____Eyelid/Under-eye Rejuvenation

_____PIcoSure Focus Rejuvenation

_____PhotoFacial (IPL/BBL)

_____XEOMIN

_____ Non-Ablative Skin Rejuvenation

_____Dermal Fillers

_____Hollywood Carbon Peel

_____MicroLaserPeel Ablative Laser

_____MIRAPeel Wet Dermabrasion

_____ Tixel Skin Resurfacing

BODY:

_____Cellulite Treatment

_____Fat Transfer: what area? _____

_____ Non-Surgical Body Contouring

_____Skin Tightening

_____Tickle Lipo

FEMININE REJUVENATION:

_____FemiLift

TATTOO REMOVAL:

_____PicoSure Tattoo Removal

UNDERARM SWEAT/ODOR TREATMENT:

_____miraDry

Have you ever received any treatments above? Yes / No

If so, please list…_____

What type of problem are you consulting for:

____Sunspots ____Wrinkles ____Enlarged blood vessels

____Flushing of the skin ____Large pores ____Sweating

____Body contouring ____Cellulite

____Other:_____

How many years have you noticed this problem?_____

At what age did your skin problem begin?_____

Are your present skin problems getting more pronounced?_____

Do you have a history of: (check all that apply)

_____Heart disease _____Diabetes _____Bleeding disorders

_____Herpes sores _____Dark spots after pregnancy _____Skin injury

_____Bruising _____Skin cancer, or suspicious moles

Do you have any allergic reactions to:

_____ Anesthesia _____ Latex _____ Medication(s)

If so, please specify: _____

Do you have any skin related allergies? Yes / No

*If yes, please specify:*_____

Authorization and Release

I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and psychological status.

I represent to the physicians and staff that I am at least 18 years of age or. I hereby consent to and authorize a history examination by my doctor and such assistant or staff as may be assigned by him/her.

Signature: _____ Date: _____

Photo Consent and Release

I consent and acknowledge that images will be taken of me or parts of my body before and after each procedure by Dr. Schwartz or his designee. I understand that photography, digital images and/or videos are a necessary part of planning and evaluating cosmetic procedures. I authorize the taking of photographs, digital images and /or videos in connection with the plastic cosmetic procedures involving the face, breasts, body, or extremities at the direction of my physician or physician delegate and under such conditions as may be approved by him/her. It is understood the use of photographs, digital images and/or videos are for illustrating the medical procedure and demonstration of treatment outcomes. I also give permission for my images to be used across all social media platforms and in office education. It is also understood that the use of the images will in no way reveal the patient's name unless direct permission is given.

☐ Check this box if you **do not** want your photos used on our social media pages.

Signature: _____ Date: _____

Witness: _____ Date:_____

(MINORS ONLY)

I have read the above Authorization and Release. I am the parent, guardian, or conservator of, _____a minor. I am authorized to sign this consent on his/her behalf, and I grant this consent as a voluntary contribution in the interest of public education.

Parent/
Guardian: _____ Date: _____

PREMIER VEIN & BODY by SCHWARTZ

Patient Name: _____ Date: _____

The information will help our office better evaluate your skin type so the laser treatment will be more effective.

Circle/ Check the corresponding box that applys

	0	1	2	3	4
What is your eye color?	Light blue or gray	Blue or Green	Hazel, Light Brown	Dark Brown	Brownish Black
What is the natural color of your hair?	Red, Sandy Red	Blonde	Dark blonde, chestnut, Brown	Dark Brown	Black
What is the color of your skin (unexposed areas)?	Reddish	Very Pale	Pale with beige tint	Light Brown	Dark Brown
Do you have freckles on sun- exposed areas?	Many	Several	Few	Incidental	None
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 had burns
To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
When did you last expose yourself to the sun, tanning beds or self- tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total Score: _____

Match your total score with the corresponding skin type.	Fitzpatrick Skin Type:
0-7	I
8-16	II
17-25	III
26-30	IV
Over 30	V-VI

Cancellation Policy

For cosmetic or aesthetic consultation/treatment sessions cancellations:

Please note your pre-paid $100 represents the fee for your consultation appointment. This fee is Non-Refundable but will be applied toward your cosmetic/aesthetic treatment should you choose to move forward.

We appreciate 48 hours (2 business days) notice of cancellation, so that we may work with another patient if you are unable to keep the appointment for your treatment/consultation session. Consultations cancelled with less than 48 hours notice(2 business days) or No-Shows, will forfeit their $100 pre-paid consultation fee. Treatment appointments cancelled with less than 48 hours notice(2 business days) or No-Shows, will incur a separate $100 fee.

For Laser Ablation Vein Surgery cancellations:

We appreciate 2 weeks notice of cancellation for Vein Surgeries so that we may work with another patient during your scheduled time. Surgery cancelled, rescheduled or No-Shows with less than 2 weeks notice will incur a $200 fee. Surgery cancelled/rescheduled with less than 48 hours (2 business days) notice or No-Shows, will incur a $500 fee.

For Major Surgery/Procedure cancellations:

We appreciate 2 weeks notice of cancellation for all other Major Surgery/Procedure cancellations (including but not limited to; Lipo, Body Contouring, Renuvion, MiraDry so that we may work with another patient during your scheduled time. Surgery cancelled/rescheduled with less than 2 weeks notice will incur a $500 fee on your credit card. Surgery cancelled/rescheduled with less than 48 hours (2 business days) notice or No-Shows, will forfeit the deposit paid at time of scheduling.

Patient Signature: _____ **Date:** _____

Credit/Debit Card On-File Authorization Policy

At *Premier Vein & Body by Schwartz*, our financial policy requires that a credit or debit card be placed on file prior to being seen by our providers. This allows us to provide ease of payment for the patient responsibility portion of services that your insurance doesn't cover, but for which you are liable, as well as for other financial responsibilities, such as No-Show or Late Cancellation fees. Co-pays are not included in this process and will be collected at the time services are rendered.

Your credit card information is kept confidential and secure, and no personal medical information is stored with it. For insurance claims, we will file your claim to your insurance company. After your insurance company processes your claim, the billing department will mail a statement to the address on file that will provide you with your current balance. Should you prefer to pay directly by check or other means, or wish to arrange a monthly installment plan, or have questions concerning your bill, **you must contact our business office prior to the due date** listed on the statement.

Payments to your credit card will only be processed if payment and/or arrangements are not received by the due date, and only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to your account. Furthermore, an "outstanding balance" charge of 2 % of the total bill will charge for each month that the bill remains unpaid.

Please circle: AMEX VISA MASTERCARD DISCOVER

Credit Card Number: _____

Expiration Date: _____/_____

CVV: _____

Cardholder Name: _____

Billing Address: _____

City/State/Zip: _____

PLEASE SIGN: I (we), the undersigned, hereby authorize and request *Premier Vein & Body by Schwartz* to charge my credit card, indicated above, for balances due for services rendered and amounts identified as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by *Premier Vein & Body by Schwartz* and includes No-Show or Late Cancellation fees. The authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must provide 60-day notification to *Premier Vein & Body by Schwartz* in writing, and my account must be in good standing.

Patient Signature:_____ **Date:** _____