SF Aesthetics and Laser Center

Jeannie Tsai, MD, MPH
1818 Lombard St
San Francisco, CA 94123

Tel: (415) 885-2737
www.sf-aesthetics.com

PATIENT MEDICAL HISTORY FORM

Last Name: _____ First Name: _____ Date: _____

Date of Birth: _____ Email: _____

Telephone 1*: _____ Telephone 2: _____

**This number will be used to contact you regarding any issues relating to your treatment by Dr Tsai.*

Address: _____

City: _____ State: _____ Zip: _____

In case of an emergency, please contact the following person:

Name:_____

Telephone:_____ Relationship to patient:_____

Primary reason for today's visit: _____

Are you under physician's care? YES NO

If yes, please specify: _____

How did you find our practice?

□ Referral _____	□ Event	□ Mailing	□ Advertisement	□ Other _____

Occupation: _____

Employer:_____

Do you require antibiotics prior to dental visits? YES NO

Are you allergic to any medications? YES NO

If yes, please specify: _____

Date of last gynecological visit (if applicable): _____

Menses (Circle one): Regular Irregular Not Applicable

Are you pregnant and/or planning pregnancy? YES NO

List any medication you are currently taking (including prescription and over-the-counter pharmaceuticals, vitamins and herbs):

_____

_____

_____

_____

Do you have now, or have you ever had diseases or conditions of:

	Yes	No		Yes	No
Arthritis/Joint Deformity			Heart Murmur		
Artificial Joint			Hepatitis		
Asthma			High Blood Pressure		
Bladder			Irregular Heartbeat		
Blood Clots			Liver or Gallbladder Diseases		
Cancer			Kidney Disease		
Cataracts/Glaucoma			Mitral Valve Prolapse		
Epilepsy, Seizure			Pacemaker		
Diabetes			Inflammation of veins		
Emotional/Psychiatric			Polycystic Ovaries		
Gastrointestinal Disorder			Thyroid		
Hearing Loss			Tuberculosis or Lung Disease		
Heart Attack			Sexual Transmitted Diseases		
Heart Disease					

List any other diseases or conditions: _____

List any surgical procedures you have had: _____

History/Physical/Assessment/Plan (To be filled out by Dr. Tsai)

_____

_____

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SKIN:

Have you ever had skin cancer? YES NO

If yes, please explain: _____

Has anyone in your family had skin cancer? YES NO

If yes, please explain:_____

Do you have a history of any specific skin diseases? YES NO

If yes, please explain:_____

Do you have problems with healing? YES NO

If yes, please explain:_____

Do you develop keloids (scars) after surgery? YES NO

If yes, please explain:_____

Do you bleed easily? YES NO

If yes, please explain:_____

Are you prone to herpes breakouts (fever blisters)? YES NO

If yes, please explain:_____

Do you develop skin rashes in reaction to any medications, food or the environment? YES NO

If yes, please explain:_____

Have you ever had laser skin procedures? YES NO

If yes, please explain:_____

Have you ever taken Accutane? YES NO

If yes, when was the last time? _____

Have you ever received local anesthesia (Novacaine or Xylocaine) by a dentist/doctor? YES NO

Do you have any tattoos including cosmetic tattoos? YES NO

If yes, please specify tattoo location body location: _____

Do you take aspirin on a regular basis or any blood thinners? YES NO

SOCIAL HISTORY:

Do you drink alcohol? YES NO

If yes, please explain:_____

Do you use recreational drugs? YES NO

If yes, please explain:_____

Do you smoke? YES NO

If yes, please explain:_____

Have you had or have you been exposed to HIV (AIDS?) YES NO

If yes, please explain:_____

PATIENT CONSENT TO TREATMENT & SF AESTHETICS AND LASER CENTER POLICY

Patient to initial each statement:

1. I hereby consent to all medical and laser procedures, including but not limited to administration of local anesthesia(s) which are deemed appropriate and necessary at any time while under the care of Jeannie Tsai, MD. _____
2. I understand these procedures are strictly cosmetic and an exam by Dr. Tsai does not replace an annual skin examination by a primary care physician or dermatologist._____
3. I am aware that a scar may result from any procedure, and that the appearance cannot be determined prior. I am aware of the possibility of infection, color change of skin, regrowth and recurrence. _____
4. I understand that I must call the office immediately (within an hour) in the event of an adverse or unforeseen event (blister, discoloration, etc). I understand that the best cosmetic outcome can only be attained if the doctor is aware of any adverse events._____
5. By signing this form, I acknowledge that I have read this form, that I fully understand its contents, and that I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction. I understand that I can call or return to the office at any time to ask for more information from the doctor or her staff. _____
6. I understand that I will be charged a fee of $100 if I fail to give SF Aesthetics and Laser Center 48 hours notice for the cancellation of a **weekday** appointment. I understand that I will be charged a fee of $100 if I fail to give SF Aesthetics and Laser Center 48 hours notice for the cancellation of a **weekend** appointment._____
7. I authorize the taking of treatment area photographs before, during and after the procedures. I understand that these photographs are considered medical records and may be used for medical education or research (if given written consent), NOT for advertisement or commercial use._____
8. I understand that Dr. Tsai does not perform treatments on pregnant women and I should notify Dr. Tsai if I am pregnant or if there is a possibility I am pregnant._____
9. I understand that under the *Americans with Disabilities Act*, SF Aesthetics and Laser Center is required to allow people with disabilities to bring a service animal onto the business premises in whatever areas patients are generally allowed. Service animals are animals that are individually trained to perform tasks for people with disabilities. Service animals are working animals, not pets. Service Animals are addressed in California law under *Civil Code Section 54.1(6*) through *54.1(7)(b).*_____
10. I understand that, in the interests of safety, all children under 18 years of age must be accompanied by a parent or responsible adult at all times while on the premises of SF Aesthetics and Laser Center. ___
11. I understand that, if for any reason, treatment charge(s) are contested or social media review(s) are posted online, I give SF Aesthetics and Laser Center permission to discuss my treatment and history with third parties. In this particular case, I waive my HIPPA privacy protection. _____
12. I understand that if I do not comply with Dr. Tsai's medical recommendation regarding my current treatment or results, SF Aesthetics and Laser Center has the right to cease continuation of services.___

PAYMENT/OFFICE POLICY

The payment of services is due in full at the time of services. I understand that the services provided by Dr. Tsai may not be covered benefits under my insurance plan, and that the procedure is performed strictly for cosmetic purposes and not medically necessary. I will be responsible for payment in full, and fully accept that the charges are out of pocket expenses and will not be reimbursed by my health care plan.

I have completed this form completely and accurately and hereby certify that I am the patient or the duly authorized general agent of the patient authorized to furnish the information requested.

_____ _____ / _____ / _____

Signature of Patient or Parent/Responsible Party Date

_____ _____

Printed Name of Signatory Relationship

Notice of Receipt: Notice of Privacy Practices

Jeannie Tsai, MD, MPH
SF Aesthetics and Laser Center
1818 Lombard St
San Francisco CA 94123
415 885 2737

I hereby acknowledge that I have received/viewed a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current Notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

□ I would like to receive a copy of any amended Notice of Privacy Practices by email.

Name of patient (please print):_____

Name of parent/guardian (if applicable):_____

Relationship to patient (if applicable):_____

Patient/parent/guardian signature:_____

Date: _____