CAROLINA HORMONE & HEALTH CENTER
THE RETREAT AT CHHC
Life is meant for living, not just existing.

# AESTHETICS PAPERWORK

**Contact Information**

Name: _____ Date: _____
Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Phone # -Home: _____ Cell #: _____
Work #: _____ Employer: _____
Where/When are the best times to reach you? _____
SSN: _____-_____-_____ Driver's License #: _____
May we send text messages regarding appointments to your cell #? ☐ Yes ☐ No

Name of Physician: _____ Phone #: _____
Date of Last Physical Exam: _____ Purpose: _____
Preferred Retail Pharmacy: _____ Phone #: _____
Preferred Compounding Pharmacy: _____ Phone #: _____

**Insurance Information**

Primary Insurance Company: _____ ID#: _____
Policy Holder Name: _____ DOB: _____

Secondary Insurance Company: _____ ID#: _____
Policy Holder Name: _____ DOB: _____

**Marital Information**

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower
Spouse/Partner's Name: _____ DOB: _____
Spouse/Partner's Phone #: _____

**In Case of Emergency**

Emergency Contact: _____ Phone #: _____
Relationship to Patient: _____
Address: _____ City: _____ State: _____

How did you hear about Carolina Hormone and Health Center or who may we thank for referring you? _____

Other family members seen by us? _____



300 West Coleman Blvd. Mt Pleasant, SC 29464
(843) 606-2530 | Fax: (843) 606-2596

3231 Sunset Blvd. West Columbia, SC 29169
(803) 454-8500 | Fax: (803) 454-8505

# MEDICAL HISTORY

*Do you have / have you had any of the following diseases or health problems?*

Patient Name: _____ DOB: _____

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma / Lung Disease / Hay Fever / Respiratory Allergies
- ☐ Blood Transfusion
- ☐ Cancer / Skin Cancer
- ☐ Cardiac Disease / Increased Lipids
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Drug Allergies
- ☐ Headaches / Migraines
- ☐ Heart Disease / Blood Pressure / Stroke
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV
- ☐ Hives/ Skin Allergies
- ☐ Hypertension
- ☐ Keloids
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Major Accident(s)
- ☐ MRSA / Staph Infection
- ☐ Mitral Valve Prolapse
- ☐ Peptic Ulcer
- ☐ Psychiatric Problems
- ☐ Recent Weight Loss or Gain
- ☐ Seizures
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Varicosities / Phlebitis

Please list all medications you are currently taking, including OTC's, supplements & vitamins.

| Name | Purpose | Name | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Are you currently using any form of Testosterone or Hormone Therapy? ☐ Yes ☐ No

If yes, please check (✓) which type:

☐ Cream ☐ Gel ☐ Pills ☐ Patches ☐ Injections ☐ Pellets ☐ Other _____

Please list any form of Testosterone or Hormone Therapy you have used in the past year: _____

_____

Please list any medications that you are allergic to: _____

Please list any major surgeries or hospitalizations in the past 5 years: _____

_____

Name of Physician & Their Specialty: _____

Date of Last Physical Exam: _____ Purpose: _____

Date of last full body dermatology exam: _____

Are you pregnant? ☐ Yes ☐ No Are you planning to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No



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Patient Name: _____ DOB: _____

Do you smoke cigarettes, cigars, or vape? ☐ Yes ☐ No

If yes, amount per day? _____ How many years? _____

Do you use smokeless tobacco? ☐ Yes ☐ No

If yes, how often per day? _____ How many years? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often and how much do you consume? _____

Do you use marijuana or other illegal substances? ☐ Yes ☐ No

Substance: _____ How often? _____

Average stress level on a scale of 1-10, with 10 being the highest: _____

Significant Stress in Your Life: _____

## COSMETIC HISTORY

What is your heritage? (ex: Italian, Indian, Hispanic, Asian, etc.) _____

Do you have a history of cold sores? ☐ Yes ☐ No

Do you get facials? ☐ Yes ☐ No

Do you have any tattoos? ☐ Yes ☐ No If yes, where? _____

Have you ever had any facial fillers? _____ If yes, when and what kind? _____

_____

Have you ever been told that you have Rosacea? ☐ Yes ☐ No

Have you ever used Accutane? ☐ Yes ☐ No If yes, when? _____

Please list any medical skin care prescriptions you are using: _____

Have you used / are you using any of the following?

- ☐ Retin A
- ☐ Tazorac
- ☐ Differin
- ☐ Retinol
- ☐ Acid Products (ex: Glycolic, Salicylic)
- ☐ Metrogel
- ☐ Doxycycline
- ☐ Minocycline
- ☐ Aspirin
- ☐ St. Johns Wort
- ☐ Steroids

Have you had any of the following treatments?

- ☐ Microdermabrasion
- ☐ Chemical Peel
- ☐ Laser Treatments / Laser Hair Removal
- ☐ Waxing
- ☐ Electrolysis
- ☐ Microneedling

Do you have any facial implants? ☐ Yes ☐ No

If yes, please list: _____

_____

Patient Name: _____ DOB: _____

Please list current skincare regime: _____

_____

Any fear of needles? ☐ Yes ☐ No

Please rate your pain tolerance on a scale of 1-10, with 1 being a HIGH pain tolerance and 10 being a LOW pain tolerance: _____

Have you ever had a vasovagal response (fainting)? ☐ Yes ☐ No

If yes, please explain: _____

Do you wax or use depilatories? ☐ Yes ☐ No

Do you use a bath puff to exfoliate? ☐ Yes ☐ No

Do you use a loofah or sponge on your face or body? ☐ Yes ☐ No

Do you sunbathe? ☐ Yes ☐ No

Do you use SPF? ☐ Yes ☐ No If yes, what kind? _____

Do you use a tanning bed? ☐ Yes ☐ No If yes, how often? _____

Are you currently using self-tanner or bronzer? ☐ Yes ☐ No

Please feel free to provide us with any other information you feel is pertinent to your medical history. The more information we have, the better we are able to assist you with your present symptoms.

_____

_____

_____

*Please sign, indicating all information provided is accurate and complete.*

Patient Signature: _____ Date: _____

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Date of Birth: _____ Today's Date: _____

***Please read the following statements carefully.***

**PURPOSE OF CONSENT:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare options.

**NOTICE OF PRIVACY PRACTICES:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent form. This notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our notice accompanies this consent form. We encourage you to read it carefully before signing this consent.

We reserve the right to change our privacy policies as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice which will contain all changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices, included any revisions of our notice, at any time by contacting either office location's Practice Manager.

**Charleston: (843) 606-2530**
**Columbia: (803) 454-8500**

**RIGHT TO REVOKE:** You will have the right to revoke consent at any time by giving us written notice of your revocation submitted to the Practice Manager of each individual office location listed above. Please understand that revocations of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

Please list anyone you would like to be allowed to review your protected health information if/when in the event you are unavailable.

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____
4. Name: _____ Phone: _____

**VOICEMAIL/ TEXT MESSAGES:** Please check (✓) one

☐ I give permission for Carolina Hormone and Health Center staff members to leave messages, with discretion, on voicemail or via text for the phone numbers listed above.

☐ Confidential information may **not** be left on voicemail.

**ACKNOWLEDGMENT:** I, _____, have had full opportunity to read and consider the content of this Consent Form and you Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative/parent guardian on behalf of the patient, please complete the following:

Representative's Name: _____
Relationship to Patient: _____
Signature: _____

# CANCELLATION / NO-SHOW POLICY

1. **CANCELLATIONS:** We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. Due to high demand of our time and providers, we have set policies in place to ensure we can provide our patients with the best possible care.

**Please allow at least 24 hours' notice for cancellation or rescheduling to avoid being charged the fee of fifty dollars ($50).** Reminder confirmation texts and phone calls are sent to each patient. Our inability to contact you to confirm your appointment does not constitute an exemption from our cancellation policy. It is the patient's responsibility to cancel their scheduled appointment. You have the ability to cancel by calling the Charleston office at (843) 606-2530 or the Columbia office at (803) 454-8500. We have a 24 hour answering service.

2. **NO SHOWS:** Patients who do not show up for their appointment and do not call to cancel their appointment at least 24 hours in advance will be considered a No Show. **If you No Show your appointment, you will be charged a fee of fifty dollars ($50).**

3. **LATE APPOINTMENTS:** As a courtesy to all patients on time for their appointments, if you arrives 10 minutes or more past your scheduled appointment time, we reserve the right to reschedule your appointment and **you will be charged a fee of fifty dollars ($50).**

**A card will be required and added to your patient profile. This card will only be charged if necessary to fulfill our cancellation/no-show policy.**

*Please sign, indicating you have read, understand, and agree to the above policies.*

Patient Signature: _____ Date: _____
(or Legal Representative)

# PHOTO / VIDEO / SOCIAL MEDIA RELEASE

NAME: _____

*Please Initial The Required Section below.*

_____ I understand that a photograph or recording is **required** for medical records at Carolina Hormone and Health Center and The Retreat, and will be kept on file for such purposes, even after completion of the treatment.

*Please Initial Any Of The Following That Apply:*

_____ I grant permission for **all** images, recordings, and likenesses to be used in, but not exclusive to, internet, website, social media (Facebook, Twitter, Snapchat, Instagram, or Pinterest), billboard, TV/cable, and/or radio.

_____ I grant permission for images, recordings, and likenesses **with eyes covered or blacked out** to be used in, but not exclusive to, internet, website, social media (Facebook, Twitter, Snapchat, Instagram, or Pinterest), billboard, TV/cable, and/or radio.

_____ I grant permission for images, recordings, and likenesses to be used in internal marketing including, but not exclusive to, office displays, waiting room tvs, and brochures.

*Please sign, indicating you have read, understand, and agree to the above policies.*

Patient Signature: _____ Date: _____



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# ASPIRIN / NSAID ACKNOWLEDGMENT

Are you currently taking Aspirin, NSAID, Plavix, Coumadin, Omega 3s/Fish Oils or any other blood thinner medications? ☐Yes ☐No

If yes, please list:

_____

_____

If you are currently taking **ASPIRIN**, **NSAIDs**, or **Omega3s/Fish Oils**, you will need to abstain from taking this medication for three days prior to your treatment.

If you have **atrial fibrillation**, do **NOT** discontinue blood thinners.

*Please sign, hereby acknowledging that the above information is correct and you understand that some treatments cannot be completed if you have not followed medical instructions.*

Patient Signature: _____ Date: _____
(or Legal Representative)



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