Estea Laser & Cosmetic Center

Date: _____/_____/_____

Name: _____ Age: _____ DOB: _____/_____/_____
*Nombre* *Edad* *Fecha de nacimiento*

Address: _____ Apt #_____ City: _____ State: _____ Zip: _____
*Direccion* *Ciudad* *Estado* *Codigo postal*

Home tel: (_____) _____ Cell: (_____) _____ Work tel: (_____) _____
*Numero de telefono* *Celular* *Numero de trabajo*

Email: _____ □ Female □ Male
*Correo electronico* *Mujer* *Hombre*

Emergency contact: _____ Relation: _____ Phone: (_____) _____
*En caso de emergencia* *Relacion* *Numero*

How did you hear about our office? _____
*¿Cómo se enteró de nuestra oficina?*

Have you been to our website? □ No □ Yes Was our website helpful? □ Yes □ No, please list reason: _____
*¿Has estado en nuestro sitio web?* *¿Fue útil nuestro sitio web?*

Is it okay to send mail to your address: □ No □ Yes Email blast: □ No □ Yes Leave messages on #'s above: □ No □ Yes
*¿Está bien enviar un correo a su dirección?*

What is the reason for your visit today? (Check all applicable procedures below)
*¿Cuál es el motivo de tu visita hoy? (Marque todos los procedimientos aplicables a continuación)*

| **COSMETIC** | | **MediSpa** | | | |
|---|---|---|---|---|---|
| □ Liposuction | □ Varicose Veins | □ Laser Hair Removal | □ Acne Treatment | □ Botox | □ Obagi Medical |
| □ Tummy Tuck | □ Brachioplasty | □ Tattoo Removal | □ Skin Tightening | □ Microneedling | □ Revision |
| □ Fat Transfer | □ Skin Tags/Moles | □ Laser Vein Removal | □ Cellulite Treatment | □ Chemical Peels | □ Hair Loss |
| □ Breast Surgery | □ Eyelid/Browlift | □ Sclerotherapy | □ Pigmented lesions | □ IPL/Photofacials | □ Hyperhidrosis |
| □ Face/Neck Lift | □ Stem Cells | Dermal Fillers: | □ Restylane | □ Juvederm | □ Versa □ Radiesse □ Bellafill |
| □ Other: _____ | | Other: _____ | | | |

Have you consulted with other physicians about procedure(s) indicated above? □ No □ Yes
*¿Ha consultado con otros médicos sobre los procedimientos indicados arriba?*

Is this procedure a revision from a previous surgery? □ No □ Yes If yes, how many previous surgeries? _____
*¿Es este procedimiento una revisión de una cirugía previa?* *Si es así, ¿cuántas cirugías previas?*

What is your "ideal time frame" for procedure(s) completion? _____ Interested in financing? □ No □ Yes
*¿Cuál es su "período de tiempo ideal" para la finalización de los procedimientos?* *¿Está interesada en financiar?*

**OFFICE USE ONLY-**

PLEASE GO TO PAGE 2 ⇒ *SIGUA A LA SEGUNDA PAGINA*

DESIRED PROCEDURES: 1. _____ 2. _____ 3. _____

AGE: _____ H: _____ W: _____

PMH: _____

_____

FAMILY HX: _____

PSH: _____

_____

ALLERGIES: _____

MEDICATIONS: _____

_____

_____

SOCIAL HX: _____

TOBACCO: _____ ETOH: _____ DRUGS: _____

PE:

ASSESSMENT:

PLAN/ORDERS:

**Are you allergic to any medication**? ☐ YES ☐ NO
*Es alergico a algun medicamento?* If yes, please list: _____

**List all medications you are currently taking:**
*Liste todo medicamentos que esta tomando:*

_____
_____
_____

☐birth control pills
☐over-the-counter vitamins
☐herbals
☐diet pills

**Do you have now, or have you ever had any of the following (Circle Yes or No):**
*Marque si tiene o a tenido alguna condicion:*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| High blood pressure | Y N | Hepatitis | Y N | Kidney problems | Y N | Heart Disease | Y N |
| Diabetes | Y N | Anemia | Y N | Dialysis | Y N | Pacemaker | Y N |
| Asthma | Y N | Bleeding problems | Y N | Cancer | Y N | Heart palpitations | Y N |
| Shortness of breath | Y N | Blood transfusions | Y N | Thyroid disease | Y N | Heart murmur | Y N |
| Chest pains | Y N | Blood clot history | Y N | Liver disease | Y N | Rheumatic Fever | Y N |
| Stroke | Y N | Blood disorders | Y N | Gastric reflux | Y N | Swelling of ankles | Y N |
| Seizures | Y N | HIV/AIDS | Y N | Stomach problems | Y N | Artificial joints | Y N |
| Emphysema | Y N | Eye Disease/Glaucoma | Y N | Depression | Y N | Abnormal scarring | Y N |

**List any other diseases or conditions:**
*Liste alguna otra condicion medica que no este arriba:*

_____
_____

Seasonal allergies? ☐ NO ☐ YES
***¿alergias estacionales?***

Trouble with dryness, soreness, burning, itching or excessive tearing of eyes? ☐ NO ☐ YES
*¿Problemas con sequedad, dolor, ardor, picazón o lagrimeo excesivo de los ojos?*

Have you ever had skin cancer? ☐ NO ☐ YES Type _____ When? _____
*¿Alguna vez has tenido cáncer de piel? Tipo? Cuando?*

Do you have a history of any other specific skin diseases? ☐ NO ☐YES
*¿Tiene antecedentes de alguna otra enfermedad específica de la piel?*

Do you develop skin rashes in reaction to ☐ Bandages ☐ Topical Neosporin (antibiotic) ☐ Latex
*¿Desarrolla erupciones cutáneas como reacción a los vendajes, a la neosporina tópica (antibiótico), al látex?*

Did you ever use a tanning parlor? ☐ NO ☐ YES
*¿Alguna vez usaste una sala de bronceado?*

**Previous surgery, list type(s) and date(s):**
*Historial de operaciones,liste tipos y fechas*:

_____
_____
_____

Have you had difficulty with ☐ Local anesthesia ☐ General anesthesia?
*A tenido dificultad con anestesia local anestesia general*

Do you smoke? ☐ YES ☐NO Drink alcohol? ☐YES ☐NO Drugs? ☐YES ☐NO
*Fuma? Toma alcohol? Drogas?*

What is your Height: _____ Weight: _____ Occupation: _____ Race / Ethnicity: _____
*Estatura? Peso? Ocupacion? Origen etnico?*

*FOR WOMAN ONLY*: Are you pregnant or trying to get pregnant? ☐ YES ☐NO Due Date:____/_____
*Solo para mujeres: Esta embarazada o esta tratando de quedar embarazada?*

I understand that if I am trying or I become pregnant I will stop all oral/topical medications you have prescribed and contact this office.

Number of pregnancies:_____ Number of live births:_____
*Embarasos? Nacimientos?*

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# HIPAA PRIVACY PRACTICES CONSENT FORM

Patient Name: _____

D.O.B.: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by accreditation and/or health and government agencies in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request. You are voluntarily signing this form and authorize the use and disclosure of your health information as described above.

**I, _____date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**