Youthful Images
Patient Information

Date _____

Patient Name: _____
FIRST **MIDDLE** **LAST**

Name you prefer to be called: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: Married ____ Single ____ Date of Birth: _____ Age: _____ Sex: ____M ____F

Race: ____ American Indian/Alaskan Native ____ Asian ____ Black or African American ____ Pacific Islander ____ Caucasian

Ethnicity: ____ Hispanic or Latino ____ Non-Hispanic or Latino

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____ Ext: _____

I prefer to be contacted at my: home / cell / work phone number (please indicate)

_____ You may contact me at either number

E-mail address: _____ _____ You may contact me via the internet

Name and address of your Primary Care Physician:

_____

If the patient is a minor, name and address of parent or guardian:

_____

HOW WERE YOU REFERRED TO *YOUTHFUL IMAGES* ?

_____ web site – YouthfulImages.com _____ other web site * _____ friend or relative *

_____ physician * _____ other *

* please specify _____

CONSENT TO BE PHOTOGRAPHED

I consent to be photographed before, during and after my treatment. I understand that these photographs shall be the property of ***Youthful Images*** as a part of my permanent patient record, and will not be shared without my authorization.

Signature of Patient, Parent or Guardian _____

CONSENT TO USE PHOTOGRAPHS

I understand and agree that my photographs may be used for internal patient education.

Signature of Patient, Parent or Guardian _____

CONFIDENTIALITY AGREEMENT

I understand my records and photographs are strictly confidential. The contents of my records cannot be released to any person or organization without my prior written approval, excluding peer review.

Signature of Patient, Parent or Guardian _____

CONSENT TO RELEASE INFORMATION

I hereby give permission to release and/or discuss information regarding my appointments, medical treatments, and related information to the following people:

Name: _____ Relationship to patient:: _____

Signature of Patient, Parent or Guardian _____

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

I understand and agree that information regarding my appointment will be released to my Primary Care Physician.

Signature of Patient, Parent or Guardian _____

Our office is pleased to announce that we are now able to communicate information and promotions to patients digitally through means of email, texting, and our mobile application.

PLEASE INDICATE YOUR CHOICE TO PARTICIPATE OR NOT IN DIGITAL COMMUNICATION

_____ YES, I want to participate in the digital communication with professionals involved in my healthcare. I understand that I have the right to change my mind and can withdraw my permission by updating this form by checking the NO section and entering a revised date. At that point, my doctor will still be able to communicate with me through telephone, fax and traditional mail.

_____ NO, I do not (or no longer) want to participate in the digital communication with professionals involved in my healthcare. My doctor will still be able to communicate with me through telephone, fax and traditional mail.

_____
Print patient name

_____
Signature

_____
Date

Patient Name: _____

We have found that the development of ***Youthful Images*** has been greatly enhanced through feedback from our patients. Your input is very important to us for future planning. Please indicate which of the following procedures may be of interest to you at present or in the future. If you would like additional information about any of the following procedures, please ask anyone here to help you. If you are interested in a procedure that you do not see listed, please let us know.

COSMETIC SURGERY AND LASER SERVICES

Arm Lift
Augmentation of the Lips, Nasolabial Folds, Glabella or Minor Depressions
Botox Injections of Glabella or Crow's Feet
Breast Augmentation
Breast Lift
Breast Reduction
Buttock Lift
Cheek Augmentation
Chin Augmentation
Ear Pinning
Enlarged Male Breasts
Eyelid Lift
Face, Neck and Forehead Lift
Facial Liposculpturing
Fat Injections to the Nasolabial Folds or Glabella
Laser Resurfacing of Face
Liposuction
Nose Reshaping
Spider Vein Treatment
Thigh Lift
Tummy Tuck
Other _____

SKIN CARE SERVICES

BioMedic MicroPeel for the Face, Neck or Hands
BioMedic MicroPeel Plus for the Face
Hair Removal via and Lightsheer laser
Parisian Peel
Photorejuvenation
Rejuvenize Peel
Vipeel
Vitalize Peel
Other_____

Referrals from our patients are received with a great deal of appreciation and confidentiality. If you know of anyone who would be interested in receiving information regarding ***Youthful Images***, please feel free to request information or leave their name and e-mail address with us. We will be certain to forward the requested information.

Dr. Felice's YOUTHFUL iMAGES
It's not about being young. It's about being you.

Financial Policy

Thank you for choosing Dr. Patrick Felice for your surgical needs. ***Youthful Images*** is dedicated to providing the highest quality care in the areas of cosmetic and laser surgery, as well as clinical skin-care.

The following is intended to outline the financial policies of our practice and to ensure your understanding of these policies. After reading this information, please sign below. If you have any questions, please do not hesitate to ask for clarification.

Payment Policy

Full payment for a consultation or a skin-care service is required at the time service is rendered. For your convenience, we accept personal checks, cash and all major credit cards. ***Youthful Images*** does not participate with any insurance carriers. We will not submit information, (codes, notes, pictures, etc.), on your behalf to any insurance company.

If it is necessary for you to cancel or re-schedule your appointment, ***Youthful Images*** must receive at least 24 hour notice of that change.

Financial Policy for Cosmetic procedures

Patient Consent for Use of Credit Cards, Debit Card, and Financing: Services performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise.

A minimum deposit of 50% of the total procedure fee is required before a surgery will be scheduled. The balance due must be received two weeks prior to your procedure. We will only accept certified bank checks, money orders, cash or major credit cards.

Unless full payment is received two weeks prior to your scheduled procedure, *Youthful Images* reserves the right to cancel or reschedule your surgery.

Should it become necessary for you to cancel or re-schedule your surgery, an administrative charge of 10% of both the surgical and anesthesia fees will be retained by Youthful Images. All pre-operative written material, including prescriptions given at the pre-operative visit must be returned before any refunds can be released.

Your Cosmetic Consultation

The fee for a cosmetic consultation is $95. The consultation fee will be deducted from any anesthesia related surgical procedure fee that is greater than $1,000.

You will meet with Dr. Felice, as well as Nancy Russo, RN, CNA, BC our Clinical Administrator. As it is our aim to thoroughly educate each of our patients, Dr. Felice and Ms. Russo welcome any and all questions during your consultation. It may be helpful to write down your questions regarding the procedure you are interested in before coming to the office.

To ensure your safety and satisfaction, Dr. Felice will conduct a thorough exam. You and he will consider your medical history, discuss your areas of concern and treatment options and take pictures of those areas. You will also review before and after pictures of several of our patients who have had a similar procedure performed. Ms. Russo will discuss any pre-operative considerations, including the anticipated post-surgical recovery period. She will also explain the breakdown of fees and the total cost.

_____

Patient Name (printed)

_____ _____

Patient Signature (or Guarantor if Patient is a Minor) **Date**

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Medical Evaluation Form

Name _____ **Date**_____

Age_____ **Gender** **M / F** **Height**_____ **Weight**_____

***Allergies—**list both drug & environmental (penicillin, local anesthetic, topical products or **LATEX**)

_____

1. Please describe your reasons for seeking consultation: _____

_____

2. Medical History:

yes no Skin Disorders: (rashes, burns, scars, cancers)
If yes, please describe _____

yes no Eyes, Ears (cataracts, glaucoma, tinnitus, hearing impaired, dizziness)
If yes, please describe _____

yes no Throat (strep throat, difficulties swallowing)
If yes, please describe _____

yes no Nose (allergies, snoring, sinus infections)
If yes, please describe _____

yes no Lungs (asthma, emphysema, bronchitis, shortness of breath)
If yes, please describe _____

yes no Heart (MVP, irregularities, angina, high blood pressure, chest pain)
If yes, please describe _____

yes no Digestive (indigestion, reflux, ulcers, colitis)
If yes, please describe _____

yes no Breasts (cysts, pain, nipple discharge, cancer)
If yes, please describe _____

yes no Pelvic (fibroid, ovarian cysts, cancer)
If yes, please describe _____

yes no Menstrual Cycle (regular, irregular, degree of cramps, rate of flow)
If yes, please describe _____

yes no Urinary (bladder infections, bladder control, blood in urine)
If yes, please describe _____

yes no Neurological (headaches, neck, back or extremity pain/tremors, seizures)
If yes, please describe _____

yes no Endocrine (diabetes, hyper/hypothyroidism)
If yes, please describe _____

yes no Mental Status (anxiety, depression, eating disorder)
If yes, please describe _____

Office Use Only:
Notes

yes no Bleeding disorders (frequent bruising, abnormal bleeding)

If yes, please describe _____

yes no Immune (HIV, Herpes/Cold Sores, Hepatitis B/C, etc)

If yes, please describe _____

yes no Other

If yes, please describe _____

3. Medications:

List all prescription, over the counter and natural supplements with dose and frequency. Include herbs, vitamins and aspirin use.

Medication	***Daily Dosage***
1	
2	
3	
4	
5	
6	

4. Surgery:

List all surgeries with date and any complications:

Surgery	***Date***	***Complications***
1		
2		
3		

5. What type of work do you do? (inside or outside the home, please describe)

_____

6. Do you smoke? (what and how much per day)

_____

7. Do you drink alcohol? (how frequently)

_____

8. What types of foods do you eat?

____

9. Family Health History:

List diseases (diabetes, heart disease, cancer etc.)

Siblings or your children	***Maternal Side***	***Paternal Side***

Office Use Only:

Notes

10. Make a list of the various aspects of wellness that **are important to you:**
(e.g., prevention of disease, aging, mood control, weight control, libido, etc.)

11. Current Skin Care Regimen (List products used, how often, etc)

Patients: I certify that I have completely reviewed the above pages/information for completeness and/or changes.

Date: _____

Signature: _____

Office: I certify the supplied information has been reviewed with the patient.

Date: _____

Signature: _____

Office Use Only:

Notes

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Clinical Skin Evaluation

Patient Name: _____ Date: _____

Have you ever seen a dermatologist for your skin? yes no

Have you ever or are you currently taking any of the following medications?

_____ **Coumadin** _____ **Accutane** _____ **Minocyn** _____ **Aspirin**

If you answered yes, please tell us when?_____

Have you ever had a **skin allergy**? (i.e. cosmetics, fabrics, latex, salicylic or glycolic acids, etc.) yes no

If yes, please explain._____

The Parisian Peel Microdermabrasion should be avoided for individuals with **HIV, uncontrolled diabetes, suspected TB or pregnancy**. Is there a possibility that you may have one of these conditions?

_____ Yes _____ No If yes, please explain._____

Would you describe your pigmentation as: Even Uneven Birthmark Pregnancy Mask

Do you have broken capillaries? yes no Nose Cheeks Chin Forehead Entire Face

Do you have acne or periodic breakouts? yes no

Pimples Whiteheads Blackheads Enlarged Pores Flakiness Acne Scars

Do you have: Deep Wrinkles Crows Feet Fine Lines

Do you wear contact lenses? yes no

Do you form thick or raised scars from a cut or burn? yes no

Do you use a sunblock when outdoors? yes no

What SPF do you use? _____

Do you use chemical self-tanning lotions? yes no

Have you or members of your family had skin cancer? yes no Location _____

Have you ever had any of the following hair removal treatments? bleach electrolysis epilation wax pluck shave

When was your last hair removal treatment? _____

What color is the hair in the area to be treated? _____

Have you had Botox or any type of filler injection within the last 2 weeks? _____ Yes _____ No

Have you undergone Laser Resurfacing with the past 12 weeks? _____ Yes _____ No

Have you had a glycolic or TCA peel within the past 8 weeks? _____ Yes _____ No

How do you wish to improve your skin? _____

_____

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SKIN TYPE

Patient Name: _____ **Date:** _____

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes color of eyes, hair, etc. The way your skin reacts to sun exposure is another important factor in correctly assessing your skin type. Recent tanning (sun bathing, artificial tanning or tanning creams) has a major impact on the evaluation of your skin color.

Please fill this out by circling the ***most appropriate*** response.

Genetic Disposition

Score	*0*	*1*	*2*	*3*	*4*
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Hazel/Brown	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut/Dark Blonde	Dark Brown	Black or Brownish Black
What is the color of your Non-exposed skin?	Reddish	Very Pale	Pale with Beige tint	Light Brown	Dark Brown
Do you have freckles in unexposed areas?	Many	Several	Few	Incidental	None

Score	*0*	*1*	*2*	*3*	*4*	*5*	*6*
Which best describes your ancestry?	English, Irish	German, Polish, Swedish	Italian, Spanish, Mediterranean	Jewish, Hispanic, Mexican, French	Asian	Light African American, American Indian	Dark African American

Reaction to Sun Exposure

Score	*0*	*1*	*2*	*3*	*4*
What happens when you stay in the sun too long?	Painful redness blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
When moderately exposed to the sun, to what degree do you tan?	Hardly or not at all or burn do not tan	Light color tan	Reasonable tan	Tan very easily	Turn dark brown very quickly
After several hours of sun exposure, do you tan?	Never or burn	Seldom	Sometimes	Often	Always
How does you face react to the sun?	Very Sensitive	Sensitive	Normal	Very resistant	Never had a problem

Tanning Habits

When did you last expose your body to sun (or artificial sunlamp/ tanning cream)?	More than 3 months ago	2–3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
When in the sun, do you expose the area to be treated?	Never	Hardly ever	Sometimes	Often	Always

Office use only: **Skin Type Scale**

◄	Genetic Disposition Score	**I**	**0-7**
◄	Reaction to Sun exposure Score	**II**	**8-16**
◄	Tanning Habits Score	**III**	**17-25**
◄	**Total Score**	**IV**	**26-30**
◄	**Skin Type**	**V-VI**	**Over 30**

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ANNUAL MEDICAL INFORMATION UPDATE

Please update our records

Patient Name _____
FIRST **MIDDLE** **LAST**

Address _____

_____

Home Phone Number _____ Cell Phone Number _____

Work Phone Number _____ Ext _____

E-mail address _____ ____You may contact me via the internet

ALLERGIES to LATEX ☐ yes ☐ no **ALLERGIES to MEDICATIONS ☐ yes ☐ no**
List: _____
_____
_____

CURRENT MEDICATIONS (include herbs & vitamins)
List: _____
_____
_____

Smoking Status:	Currently Smoking	☐ yes	☐ no
	Currently using Nicotine Patch or Gum	☐ yes	☐ no

Describe in detail any of the following items marked (YES) and any other changes in your medical status:

MVP(Mitral Valve Prolapse)	☐ yes	☐ no	Cardiac Changes	☐ yes	☐ no
Cancer	☐ yes	☐ no	HIV	☐ yes	☐ no
Diabetes	☐ yes	☐ no	Hepatitus B, C, other	☐ yes	☐ no
Thyroid Changes	☐ yes	☐ no	Recent Surgery	☐ yes	☐ no
Dry Eye	☐ yes	☐ no			

Mental Status/Life Changes (depression, anxiety, divorce, death of spouse)	☐ yes	☐ no
Other Medical Changes (pregnancy, asthma, etc…)	☐ yes	☐ no

Explanation of any items marked YES

_____
_____
_____

Patient Signature _____
Date: 12/13/2016

Update entered to IMS _____