

# JUPITER

## DERMATOLOGY & HAIR RESTORATION

Name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_  
 Street address: \_\_\_\_\_ City: \_\_\_\_\_  
 Zip code: \_\_\_\_\_ State: \_\_\_\_\_ Social Security#: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_  
 Daytime phone number: ( ) \_\_\_\_\_-\_\_\_\_\_ Cell phone number: ( ) \_\_\_\_\_-\_\_\_\_\_  
 Marital status (check one):  Single  Married  Divorced  Widow

How did you hear about our office? \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

### Emergency contact information

Name: \_\_\_\_\_ Home phone number: ( ) \_\_\_\_\_-\_\_\_\_\_  
 Work phone number: ( ) \_\_\_\_\_-\_\_\_\_\_ Relationship to patient: \_\_\_\_\_

### Employer information

Occupation: \_\_\_\_\_ Employer name: \_\_\_\_\_  
 Phone number: ( ) \_\_\_\_\_-\_\_\_\_\_ City, state: \_\_\_\_\_

### Medical history

Arthritis	Glaucoma	Thyroid	Melanoma	HIV+(exposure)
Chronic cough	Asthma/Bronchitis	Chest pain	Hepatitis A/B/C	Heart Murmur
Lymphoma	Squamous Cell	Basal Cell	Diabetes	Emphysema
High Blood Pressure	Cancer of breast/colon/prostate	Other cancers	_____	Mitral valve prolapse

**Reason for today's visit:** \_\_\_\_\_

**Please list any other medical conditions we need to be aware of:** \_\_\_\_\_

**Please list any surgical procedures you've had within the last 6 months:** \_\_\_\_\_

**Please list any known allergies:** \_\_\_\_\_

**Please list all medications you are currently taking:** \_\_\_\_\_

Do you drink alcohol: <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently use/have used IV drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you require antibiotics prior to surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you bleed easily? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you latex intolerant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have artificial joints/pins/screw <input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had dental anesthesia (Novocain)?  Yes  No Any adverse reactions? \_\_\_\_\_

Do you have any family history of skin cancer?  Yes  No If yes, what type? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Primary Care Phone Number: ( ) \_\_\_\_\_-\_\_\_\_\_  
 Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone Number: ( ) \_\_\_\_\_-\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE INITIAL**

\_\_\_\_\_ I understand that medical care requires my cooperation and I will follow my doctor's orders and prescriptions. I will make and keep appointments for follow-up care and call the office to note any changes or concerns regarding my condition. I authorize my physician and JDHR to take photographs/video tape or by other similar means record my surgery/procedure(s). I understand that reproduction or publication of said photographs and recordings will be used for the purpose of medical/scientific study and research, education, before and after surgical portfolios of the body to demonstrate surgery/procedures and that every effort will be made to protect the patient's identity in those materials. I further acknowledge that all recorded media obtained is that the sole property of JDHR. I hereby certify that I have read the forgoing CONSENT and fully understand the consents thereof.

\_\_\_\_\_ I understand medical consent forms will be provided to me by the doctors and staff of JDHR before treatment. I authorize my doctor to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such medical care to the third party payers, including Medicare. I authorize and request that my insurance company, in lieu or reimbursing me directly, pay to the doctor or medical group any benefits or services. I agree that I may be responsible for payment of all services rendered on my behalf of my dependents. I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have contracted lab or facility, or if services are not covered by my insurance company

**Written Acknowledge Form**  
**Receipt of Notice of Privacy Practices**

Patient's rights of disclosures: In general the HIPAA privacy rules give individuals the right to request restriction on uses and disclosures of health information. The individual is also provided to the right to request confidential communications of health information be made by alternative means.

(1) I, \_\_\_\_\_, have received a copy of the Notice of the Privacy Practices  
Patient Name

-OR-

(2) has been offered a copy of the Notice of the Privacy Practices but declined to accept a copy.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

**WRITTEN ACKNOWLEDGEMENT OF PATIENT REFUSAL TO SIGN A  
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

On the \_\_\_ day of \_\_\_\_\_, 2018, the Notice of Privacy Practices was

\_\_\_\_\_ offered and/or given to \_\_\_\_\_ Patient Name

\_\_\_\_\_ The Patient accepted a copy of the Notice of Privacy Practices but refused to sign an acknowledgement that it was given to the patient.

\_\_\_\_\_ The Patient refused to accept a copy of the Notice of Privacy Practices and refused to sign an acknowledgement that it was offered to the patient.

\_\_\_\_\_  
Signature of JDHR Employee-Offering Notice

\_\_\_\_\_  
Date

***Jupiter Dermatology & Hair Restoration***  
***Cancellation Policy/No Show Policy***

***1. Cancellation/ No Show Policy for Appointment***

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

**If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar (\$50) fee; this will not be covered by your insurance company.**

***2. Scheduled Appointments***

We understand that delays can happen however we must try to keep the other patients and doctors on time.

**If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.**

***3. Cancellation/ No Show Policy for Mohs Surgery***

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

**If surgery is not cancelled at least 10 days in advance you will be charged a seventy five dollar (\$75) fee; this is will not be covered by your insurance company.**

***4. Account balances***

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over \$100 must make payment arrangements prior to future appointments being made.

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**Print Name Patient**

**Signature Patient/Guardian**

**Date**

## Skin Care Questionnaire

**1. Please check your skin type:**

<input type="checkbox"/> Type I-	Very Fair/Blue Eyes/Freckles	Always Burn, Never Tan
<input type="checkbox"/> Type II-	Fair/ Blue, Hazel or Green Eyes	Always burn, Sometimes Tan
<input type="checkbox"/> Type III-	Cream White/Fair Skinned – Any Eye Color	Sometimes Burn, Always Tan
<input type="checkbox"/> Type IV-	Moderately Pigmented Olive or Light Brown Skin Tones (Hispanic, Asian, Indian, Middle Eastern, or Mediterranean)	Rarely Burn, Always Tan (Tan stays for months)
<input type="checkbox"/> Type V-	Darker Brown (Hispanic, Asian, Indian, Middle Eastern, or Mediterranean)	Very Rarely Burns, Tans Very Easily
<input type="checkbox"/> Type VI-	Darkest Brown/Black	Never Burns, Always Tan

**2. Is your skin:**  Dry  Oily  Combination

**3. Do you currently use sun block?**  Yes  No Product Name: \_\_\_\_\_ SPF \_\_\_\_\_

**4. Do you currently use Retin A, Tretinoin, or Renova for anti-aging?**  Yes  No

**5. Do you use any topical antioxidants or Vit C?**  Yes  No Product Name: \_\_\_\_\_

**6. Are you interested in improving the appearance of your skin?**  Yes  No

- Wrinkles & Fine Lines  Sagging Skin/Volume Loss  Jowls  Brown Spots  Tone & Texture  Pore Size  
 Redness/Broken Blood Vessels  Dryness  Acne  Pre-Cancerous Lesions  Removing Tattoos

**7. Do you want to look**  Refreshed  5-10 years younger  10-15 years younger  20+years younger

**8. Do you or have you had facial treatments done?**  Yes  No

**9. Check which treatment you have had done previously:**

- Facials  Microdermabrasion/MicroNeedling  Chemical Peels  Laser  Kybella  
 Botox  Fillers (Sculptra, Radiesse, Restylane, Juvederm, Belotero)  None

**10. What is your current makeup routine?** \_\_\_\_\_

**11. What type of foundation do you prefer (liquid, pressed) and what type of coverage (sheer/medium/full)?** \_\_\_\_\_

*I am interested in obtaining more information on the following:*

- Facial Fillers** (Sculptra, Radiesse, Restylane, Belotero, Juvederm)  **CO<sub>2</sub>/ReSurFX Laser**  
 \_\_\_\_\_ Moderate to severe facial wrinkles and folds \_\_\_\_\_ Anti aging skin resurfacing treatment  
 **Hand Rejuvenation** (restore lost volume due to aging) \_\_\_\_\_ Fractional/Fraxel Lasers

- Sculptra** \_\_\_\_\_ To improve facial volume  **Botox or Dysport** \_\_\_\_\_ Improve the appearance of wrinkles and  
 \_\_\_\_\_ To improve sagging skin \_\_\_\_\_ brow lines  
 \_\_\_\_\_ Underarm sweating

- Laser Hair Removal**  **IPL Photo-Facial/Skin Rejuvenation**  
 **Tattoo Removal** \_\_\_\_\_ To improve pigmentation/Redness/Stimulate Collagen  
 **Kybella** (Neck Fullness/Double Chin Treatment)

**Vein Therapy/ Sclerotherapy**

- Eliminate spider and varicose veins.
- Treatment of Facial Veins/Broken Vessels

**Skin Care**

- Chemical Peels       PRP
- Microdermabrasion/Microneedling
- Facials

- Sunscreens**  **Chemical Free** (Clear Zinc/Titanium Dioxide)  
 **Sport/Water Resistant**

**BluLight**

- Pretreat cancer lesions

**Hair Care/ Hair Transplant**

- Hair Loss/Thinning

**Colorescience Mineral Makeup** (Chemical Free SPF)