

ADVANCED COSMETIC & PLASTIC SURGERY

107 NEWTOWN ROAD, SUITE 2C, DANBURY, CT 06810 (203) 791-9661
901 ETHAN ALLEN HIGHWAY, SUITE 101, RIDGEFIELD, CT 06877 (203) 438-5080
22 OLD WATERBURY ROAD, SUITE 106, SOUTHBURY, CT 06488 (203) 791-9661

LIGHT SWEEP

Laser Client Information and Medical History

In order to provide you with the most appropriate laser hair removal or skin care treatment, we would appreciate your time in completing the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name _____ Today's Date _____

Date of Birth _____ Age _____ Occupation _____

Home Address _____ City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____ Email Address: _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

Which of the following best describes your skin type? (Please circle one skin type number)

- | | | | | | |
|----|------------------------------|-----|------------------------------|----|----------------------------------|
| I | Always burns, never tans | III | Sometimes burns, always tans | V | Brown, moderately pigmented skin |
| II | Always burns, sometimes tans | IV | Rarely burns, always tans | VI | Black skin |

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No

Are you currently under the care of a dermatologist? Yes No

Do you have any of the following medical conditions? (Please check all that apply)

- cancer diabetes high blood pressure herpes arthritis frequent cold sores HIV/AIDS keloid scarring
 skin disease/ skin lesions seizure disorder hepatitis hormone imbalance thyroid imbalance blood clotting abnormalities
 any active infection

Do you have any other health problems or medical conditions? Please list: _____

What oral medications are you presently taking? ACCUTANE birth control pill
 hormones others (please list): _____

Have you ever used Accutane? Yes No If yes, when did you last use it? _____

What topical medications or creams are you currently using? Retin A others (please list) _____

Have you ever had laser hair removal? Yes No

Have you used any of the following hair removal methods in the past six weeks?

- shaving waxing electrolysis plucking tweezing stringing depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma?

Yes No If yes, please describe _____

For our Female clients: Are you pregnant or trying to become pregnant? Yes No

Are you using contraception? Yes No

Are you breastfeeding? Yes No

Allergies

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced.)

food latex cosmetics aspirin lidocaine

hydrocortisone hydroquinone or skin bleaching agents others: _____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, aesthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date _____

DAVID M. GOLDENBERG, M.D.

SOHEL M. ISLAMI, M.D.

PRASHANT SONI, M.D.

**ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF:
Notice of Privacy Practices
Informed Consent
Practice Financial Policies
Notice Regarding Ridgefield Surgical Center, LLC**

ADVANCED SPECIALTY CARE

107 Newtown Road, Danbury, CT 06810
131 Kent Road New Milford, CT 06776

901 Ethan Allen Highway, Ridgefield, CT 06877
22 Old Waterbury Road, Southbury, CT 06488

Privacy Officer: Jennifer Retter, Business Manager (203) 830-4700 ext. 265

I hereby acknowledge that I was given the opportunity to review this medical practice's **Notice Of Privacy Practices (HIPAA)**, and that I have the right to ask for a paper copy of the Notice to take with me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

I authorize the person(s) listed below to discuss my medical information:

Name

Relationship to Patient

Name

Relationship to Patient

Please note that ASC employees may discuss payment issues with family members or other personal representatives, including the subscriber of my insurance plan, unless I request special privacy protections. My signature on this form authorizes such financial discussion.

Under certain circumstances, this office may need to request lab reports, radiology reports, or other diagnostic test results from outside facilities. At times these facilities may require an authorization to release such records. My signature authorizes the release of any diagnostic test results that we may require in order to provide treatment.

I understand that no procedure provided by this facility is completely without risk and I authorize the care and treatment provided to me under the general or specific directions of my physician or my physician assistant.

If this office does not have a contract with my insurance company, payment must be made at the time of visit unless prior arrangements have been made with the office manager. For patients with coverage that we participate with we will file your insurance claims to your primary carrier for all services and procedures we provide. It is your responsibility to secure all referrals and authorizations required by your health plan and to be aware of its coverage and benefits. All charges are your responsibility from the date the services are rendered. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. If payment is not received in a timely manner, my account will be turned over to a collection agency. I agree to notify the office of Advanced Specialty Care of any changes to my insurance coverage so that filing my claim is expedited.

I hereby acknowledge that I have been given an opportunity to review the posted notice to patients regarding physician ownership of Ridgefield Surgical Center, LLC.

Signature (Parent or Guardian if Patient a Minor)

Relationship To Patient

Please Print Name

_____/_____/_____
Date

Patients Name (if Minor)

_____/_____/_____
Patient's date of birth