PATIENT HISTORY QUESTIONAIRE

Name:_____Date:_____

Check all conditions that you may have.

- ☐ Blood transfusion
- ☐ Stroke
- ☐ Chemotherapy/Immunosuppression
- ☐ Rosacea/Eczema
- ☐ Circulatory Problems
- ☐ Pigmentation disorders
- ☐ Stomach problems
- ☐ Autoimmune disorders_____
- ☐ Skin Cancer_____
- ☐ Mental Disorders
- ☐ Hypertension
- ☐ HIV
- ☐ Ulcers
- ☐ Fainting
- ☐ Asthma
- ☐ Thyroid problems
- ☐ Sinus
- ☐ Phlebitis
- ☐ Kidney problems
- ☐ Wound Healing problems
- ☐ STD's_____
- ☐ Heart problems
- ☐ Bleeding Disorders (Anemia?)
- ☐ Liver problems (hepatitis)
- ☐ Herpes (oral or genital)
- ☐ Cancer Type _____
- ☐ Tuberculosis
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Inflammatory dermatitis
- ☐ Other: _____
- ☐ **I HAVE NONE OF THESE**

MEDICATIONS/SUPPLEMENTS: (List ALL current medications including birth control, antibiotics, Ginkgo Balboa, Vitamin A, B, or E, Garlic, Flax oil, **ASPIRIN**, etc.) _____

_____

ALLERGIES: (List ALL allergies including retinoic acid, latex, cosmetics, milk, sugar/beets, papaya, apples, pineapples, citrus fruits, strawberries, hay fever, bees, eggs, red dyes, hair coloring, etc.) _____

_____

HAVE YOU HAD ANY OF THE FOLLOWING: (Please circle YES or NO and list treatment)

Any Retinol products?	YES	NO	Date of last treatment_____
Any glycolic acid?	YES	NO	Date of last treatment_____
Any salicylic acid?	YES	NO	Date of last treatment_____
Any Isotretinoin in the past nine (9) months?	YES	NO	Date of last treatment_____
Any prescription for acne?	YES	NO	Date of last treatment_____
Birth Control Pill/Patch?	YES	NO	Date of last treatment_____
Steroids (oral or injection)?	YES	NO	Date of last treatment_____
Any hydroquinone or bleaching agents?	YES	NO	Date of last treatment_____

Please answer the following:

Are you pregnant? YES NO

Are you lactating? YES NO

Do you smoke? YES NO

Do you tend to scar? YES NO

After scabbing is your skin darker in color? YES NO

Do you get cold sores? YES NO

How many times a year _____

Is your skin sensitive? YES NO

Do you form Keloids? YES NO

Do you get severe allergies/skin infections YES NO

If you are out in the sun for 2 hours without sunblock you will…..

1) Always burns & never tans **4) Rarely burns & usually tans**

2) Usually burns & rarely Tans **5) Rarely burns but tans**

3) Sometimes burns & tans gradually **6) Never burns and tans quickly**

When was your last sunburn? _____

What is your ethnic background?
_____

Do you use Sunscreen? YES NO

What SPF? 15 30 50+

Tanning Beds? YES NO

What would you like information on? Please circle top 3 concerns.

Acne / Acne Scars	Black Heads	Seborrheic Keratosis	Lashes/Brows
Clogged Pores	Dark Circles under Eye	Tattoo Removal	Brown/Black Spots
Dull Skin	Leg/Facial Veins	Jaw Pain/TMJ	Freckles
Fuller Lips	Jowls	Double Chin	Longer Eyelashes
Melasma	Unwanted Hair	Permanent Makeup	Rough / Dry Skin
Rosacea	Skin Laxity	Teeth Whitening	Skin Care
Micro-Needling	Chemical Peels	Wrinkles	Cherry Angiomas
Scar Reduction	Areola/Nipple Tattoo	Camouflage	Skin Tags

List all previous surgeries:
_____

Have you had a COVID infection? YES NO

Are you vaccinated? YES NO

How many vaccine boosters have you had? _____

PREVIOUS COSMETIC TREATMENTS: Please check all that apply.

- ☐ Chemical Peels Date of last treatment _____
- ☐ Microdermabrasion Date of last treatment _____
- ☐ Laser Resurfacing Date of last treatment _____
- ☐ Waxing Date of last treatment _____
- ☐ Eye Lash Extensions Date of last treatment _____
- ☐ Age Spot Removal Date of last treatment _____
- ☐ UV Tanning Beds Date of last treatment _____
- ☐ Laser Hair Removal Date of last treatment _____
- ☐ Facial Surgery Date of last treatment _____
- ☐ Sclerotherapy Date of last treatment _____
- ☐ Botox Date of last treatment _____
- ☐ Derma Fillers Date of last treatment _____
- ☐ Micro-Needling Date of last treatment _____
- ☐ Permanent Make-up Location(s) _____

Please comment any negative outcomes to prior treatments:
_____
_____
_____

2469 Corrales Rd. Bldg. A, Suite D-1,
Corrales, NM 87048
PH: 505-897-4433/ F: 505-897-3085

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

Patients Name: _____ Date of Birth: _____

My 'protected health information" PHI, means health information, including my demographic information, collected from me and created or received from my physician, another health care provider, a health plan, my employer or a health care clearing house.

This PHI relates to my past, present and future physical or mental health or condition that identifies me, or that there is a reasonable basis to believe the information may identify me.

I consent to the use and disclosure of my protected health information (PHI) by Belleza Med Spa for the purpose of diagnosing or providing treatment to me, obtaining payment for services rendered, or as necessary to conduct health care operations of Belleza Med Spa. I understand that diagnosis or treatment of me by any physician of Belleza Med Spa may be conditioned upon my consent as evidenced by my signature of this document.

I understand that I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or healthcare operations of this practice. Belleza Med Spa is not required to agree to the restrictions that I may request. However, if Belleza Med Spa agrees to restrictions, they are binding on Belleza Med Spa and any physician of Belleza Med Spa.

I have the right to revoke this consent in writing at any time, except to the extent that any physician of Belleza Med Spa or other employees of Belleza Med Spa have taken action in reliance on this consent.

I understand that I have the right to review Belleza Med Spa's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the type of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Belleza Med Spa. This Notice of Privacy Practices also describes my rights and Belleza Med Spa's duties with respect to my PHI.

Belleza Med Spa reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain revised notice by calling the office and requesting a revised copy and have it sent via mail or to pick up at my next appointment.

_____

(Signature) (Date Signed)

_____

(Signature of Personal Representative if patient is unable to sign or under 18 years of age.)

PATIENT AUTHORIZATION FOR PHOTO/VIDEO PURPOSES

(Please read each bullet and initial the appropriate line(s) and complete bottom portion of form.)

_____ I hereby authorize Belleza Med Spa to take photographs, videotapes, or digital images of me **for document purposes only**. (This line must be initialed)

_____ I understand that Belleza Med Spa may use and release my images to the general public for the following purposes: (1) educational lectures and presentations for health care professionals; (2) scientific publications such as journals or books; (3) patient education materials; (4) broadcast, print or internet media for educational or public interest purposes. I understand my identity will not be given away unless authorized for Latisse.

_____ I understand that after the release of my images to the general public, they may be subject to re-disclosure.

_____ Unless otherwise revoked, I understand that this authorization will expire 50 year(s) from the date of signature. I understand that I may revoke this authorization at any time, except to the extent that Belleza Med Spa has relied on this authorization, by sending a written statement of revocation that specially refers to this authorization to:

_____ I give consent to allow Belleza Med Spa to post photos/videos of me on social media platforms (i.e., Facebook, Instagram, etc.).

I hereby release Belleza Med Spa and its officers, heirs, legal representatives, agents, employees, and all persons functioning under Belleza Med Spa's permission or authority or those for whom Belleza Med Spa is functioning from any and all liability connected with the capture, use or release of my images.

By signing this authorization, I acknowledge that I have read and understand the statements contained herein. I understand that Belleza Med Spa will provide me with a copy of this signed authorization form should I request one.

Print Name: _____

Signature: _____

Date: _____

If Patient has a Legal Representative, complete the following:

Print Name of Legal Representative: _____

Relationship to patient: _____

Signature of Legal Representative: _____ Date: _____

Belleza MEDSPA

PATIENT INFORMATION SHEET

(PLEASE PRINT)

Name: _____ Date of Birth: _____ Age: _____

Sex: M F Non-Binary Transgender Male Transgender Female Other:_____

Pronouns: _____

Address: _____

City: _____State: _____Zip: _____

Home Phone: _____Cell Phone: _____

Work Phone: _____ Occupation: _____

Email Address: _____

Emergency Contact Name: _____ Emergency Phone: _____

Responsible Party Information

(Only if Patient is NOT responsible Party)

Name: _____Address:_____

City:_____State:_____Zip:_____Phone: _____

Relationship to Patient: _____

How did you hear about us?

- ☐ Walk In / Drive by
- ☐ Online / Website
- ☐ Bliss Salon & Spa
- ☐ Attractions Hair Studio
- ☐ Newspaper
- ☐ Craig's List / Facebook
- ☐ Personal Reference (who?) _____
- ☐ Business card
- ☐ Mailer
- ☐ Union Newsletter
- ☐ Coupon
- ☐ Phonebook
- ☐ Booth
- ☐ Other _____

****Refer a friend and receive a $25.00 credit****

AUTHORIZATION TO RELEASE INFORMATION

I authorize the physician and staff of Belleza Med Spa to discuss my medical condition, treatment plan or any relevant subject with (i.e., husband, sister) _____ (Please Initial)

Name(s) _____

APPOINTMENT CONFIRMATION

I give Belleza Med Spa permission to confirm, leave appointment information and/or promotional information on my voicemail, cell phone, home phone, email, and text message _____ (Please Initial)

- ☐ Yes
- ☐ No

PRIMARY CARE PHYSICIAN

Name: _____ Phone: _____

DERMATOLOGIST

Name: _____ Phone: _____

POLICIES

Refunds may be granted on unused service(s) with a 20% processing fee. **_____(Initial)**

All skincare products are final sale. **_____(Initial)**

If you cancel, re-schedule or no show for an appointment within 24 hours of your scheduled time, your credit card may be charged the total amount of treatment scheduled for that day. **_____(Initial)**

******Your credit card will be charged $50 for a no show/ no call on the day of your consultation and may be charged if you re-schedule within 24 hours of your consultation.****************************** **_____(Initial)**

If you no show/ no call for an appointment you will be required to pay a deposit prior to scheduling again. **_____(Initial)**

If you are more than 5 minutes late for an appointment, we will do our best to accommodate you, but in some cases we will have to re-schedule your appointment for another time. **_____(Initial)**

We are unable to watch children for you during your treatment. If you are not able to attend your appointment without your child(ren) please re-schedule your appointment. **_____(Initial)**

Understand that Belleza Med Spa, at times, uses products/devices off label **_____(Initial)**

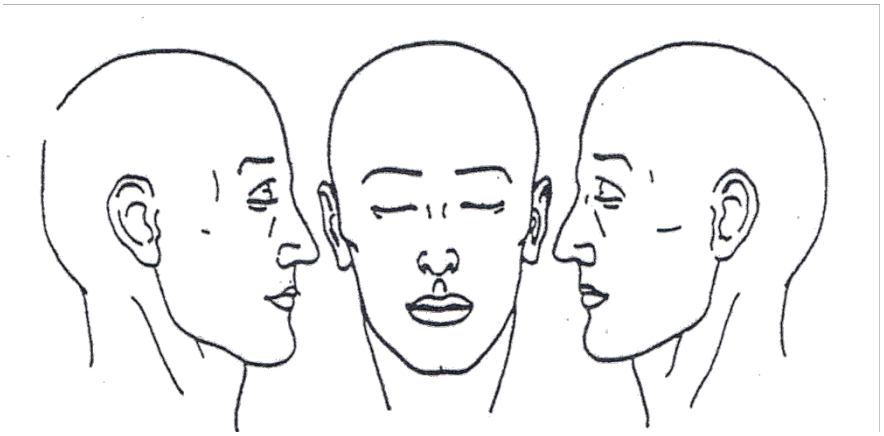
Cancelation of any appointment due to use of Retinol, Glycolic acid, Hydroquinone, and bleaching agents within two weeks before your treatment will result in a $20 fee.

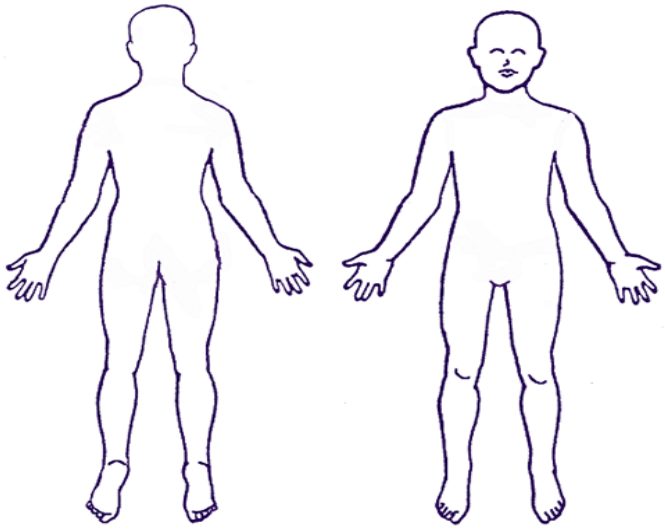
_____(Initial)

*****The office follows APS scheduling for inclement weather*****

PATIENT INDICATION SHEET

On the image below please mark with an “X” in the areas of concern





What do you use for facial cleanser? _____

What do you use for moisturizer? _____

What other products do you use? _____

Is your skin: Oily Dry or Combination

How many times do you exfoliate per week? _____

Are you prone to Acne? _____

Plan: Alcohol/Phone Change Pillowcases Avoid milk products Try probiotics

BELLEZA MED SPA LLC Policies

1) **NO SHOW/NO CALL/RESCHEDULING/CANCELLATION LESS THAN 48 HOURS PRIOR TO YOUR APPOINTMENT TIME POLICY:**

Belleza Med Spa LLC is excited to see you! We value your time and will make every effort to meet your wishes. In turn, we request that you value our time. Dr. Pacheco will meet with you for a free consultation to answer your questions. We ask that you please make every effort to arrive on time for your appointment. You will be rescheduled if you are 10 minutes late from your scheduled arrival time.

Please note that if you do not show, do not call, cancel, or reschedule less than 48 hours of your consultation time, then you have not allowed the Belleza staff enough time to fill it with another patient. You will be charged $50.00 for the lost time.

A $25-$50 fee will be charged for all non-consult scheduled appointments missed/canceled or rescheduled less than 48 hours of the scheduled time. All fees will be charged at the time of rescheduling the missed appointment.

2) **Please bring your Covid vaccination card if you have one.**
3) **Please do not bring friends or family to your appointment.**
4) **Discontinue hydroquinone, retinoid products, salicylic products 2 WEEKS prior to all laser, micro-needling, chemical peels to avoid complications.**
5) **Discontinue Accutane a minimum of 6 months prior to treatments.**
6) **Please do not schedule fillers, age spot removal and micro-needling 3 days prior to an important event or out of town trip.**
7) **Please look forward to looking your best!!**

Patient Signature_____Date_____