



MEDICAL HISTORY

CLIENT: _____

To ensure the safety of your treatment, please provide your health history to the best of your ability.

General Information

Last Name: _____ First Name: _____ M.I. _____
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-Mail Address: _____
Date of Birth: _____ Age: _____ Gender: F / M
How did you hear about us? Internet _____ Referral _____ Other: _____

My Interest

I am interested in correcting/treating the following (check all that apply):

- Photofacial /IPL, Rosacea, Age Spots, Facial vessels, Skin tightening, Scars, Fine lines/ wrinkles, Uneven skin texture, Hair Reduction, Skin Hydration Therapy, Hair Growth, Botox / Fillers, Acne

Sun Exposure

Have you had recent sun exposure for more than 20 minutes? Yes No

When you sunbathe, how does your skin respond?

- Always Burn, Never Tan, Almost Never Burn, Tan Very Easily, Usually Burn, Difficulty Tanning, Rarely Burn, Tan Easily, Sometimes burn, Average tanning, Never Burn, Always Tan

Products

Do you consistently wear sunblock SPF30 or greater? Yes / No

List the SPF _____

What topical medications or creams are you currently using? _____

Check all that have been treated or currently obtain:

- Acne/ Acne Scars, Accutane Treatment for Acne, Autoimmune Disorder, Cancer (or Radiation Therapy), Diabetes/ Diabetic Neuropahghy, Herpes or Cold Sores, High Blood Pressure, Blood Disorders, Hirsutism, Vitiligo, Kidney Disease, Melanoma, Basal Cell, Psoriasis, Shingles, Steroid or Hormonal Therapy, Hormonal Imbalances, Polycystic Ovarian Syndrome, Acne or Other Scars, Knee or Hip Replacement, Metal Implants, Keloid Scars, Smoking, Pacemaker, Pregnancy, Seizures, Epilepsy



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Additional Information

Do you smoke? Yes / No

If yes, how often? _____

Do you consume alcohol? Amount _____ Daily Occasionally Socially

Have you had any cosmetic surgery? Yes / No

If yes, please list the procedure and date _____

Are you currently under the care of a Dermatologist/Physician? Yes / No

If yes, please specify: _____

Please list all medications you are taking including herbal _____

Please list all allergies _____

Have you had any recent tanning or sun exposure that changed the color of your skin? (Lotions, beds, etc.)

Y / N If yes, when? _____

Do you have Hyperpigmentation (darkening of the skin), or Hypopigmentation (lightening of the skin) or marks after physical trauma? _____

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

History

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 Threading Depilatories

For Our Female Clients

Are you pregnant or trying to become pregnant? Yes No

Are you breastfeeding? Yes No

Are you using contraception? Yes No

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. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date _____

Technician _____ Date _____



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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

1. **Agreement To Arbitrate:** The agreement to arbitrate includes, but not limited to, any claim for medical malpractice, breach of contract fraud or misrepresentation, negligence, gross negligence, or any other claim based on any departure from accepted standards of medical or health care or safety whether sounding in tort or in contract. It is further understood and agreed that any claim for medical malpractice, breach contract, fraud or misrepresentation, negligence, gross negligence or any other claim based on any departure from accepted standards of medical or health care safety whether sounding in tort or in contract will be determined by submission to arbitration as provided by Arizona law, and not by a lawsuit or Court process except as Arizona law provides a judicial review of arbitration proceedings. Both parties to this contract, be entering into it, are voluntarily giving up their constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.
2. **All Claims Must Be Arbitrated:** The parties intend that this agreement shall cover all existing and subsequent claims or controversies whether in tort, contract or otherwise, shall bind all parties whose claims may arise out of, or in any way relate to, treatment or services provided or not provided by below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse, heirs, personal representative, guardian or any person deriving any claim though them on behalf of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertions of any claim against a Physician, including any fee dispute, whether or not the subject of any existing court action shall be resolved by arbitration.
3. **Procedures and Applicable Law:** The demand for arbitration must be commenced in writing by US mail, postage paid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses, and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. However if all parties agree, they may select an arbitrator who was not a prior court judge. Both parties agree that arbitration shall be governed pursuant to Arizona Revised Statutes, A.R.S 12-1501-12-1518, and the Federal Arbitration Act (9 U.S.C 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees, and expenses, along with a prorated share of the neutral arbitrator's fees and expenses.
4. **Revocation:** The patient understands the Arbitration Agreement may be rescinded by written notice to the Physician from the patient within 30 days of signature. If not rescinded within 30 days, this Arbitration Agreement shall remain in effect for all care and services subsequently rendered by the Physician.
5. **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Arizona and Federal law.
6. **Right to Seek Legal Counsel:** The patient understands he/she has the right to seek legal counsel concerning the agreement.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE VOLUNTARTILY AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE OR ANY OTHER CLAIM DESCRIBED IN PARAPGRAPH 1 ABOVE DECIDED BY NEAUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Patient Name (Print) _____ Patient's Signature _____

Date: _____

//Signed// Kevin Choi

Dr. Kevin Choi, Owner