DermaBella Medical Spa

7170 Smoke Ranch Rd, Suite 110 Las Vegas, NV 89128 (702) 228-0491

Personal Profile and Health History

Today's Date:_____

Last Name:_____ First Name:_____ Middle:_____

Street Address:_____

City, State, Zip:_____

Home Phone:_____ Cell:_____ Carrier: _____

E-mail:_____ Occupation:_____ Date of Birth:_____

Primary Care Physician:_____ Phone:_____

How did you hear about us?_____

Females:	□ Y	□ N	Are you pregnant?
	□ Y	□ N	Are you breastfeeding?
	□ Y	□ N	Are you planning pregnancy during the course of your treatment?
	□ Y	□ N	During pregnancy did you develop hyperpigmentation or masking?
	□ Y	□ N	Do you have regular periods?
	□ Y	□ N	Are you going through menopause?

Please complete the following items of the medical history.

List **ALL** medications including prescription and over the counter drugs, vitamins, herbs, supplements:

_____

_____

Are you allergic to any medications? □ Y □ N

If yes, please explain: _____

Medical History: Please check all that apply

□ Acne	□ Gold therapy	□ Implants	□ Psoriasis
□ Bleeding disorders	□ Heart disease	□ Kaposi's sarcoma	□ Rosacea
□ Botox	□ Hemorrhoids	□ Keloid scars	□ Seizures
□ Burns/Skin grafts	□ Herpes	□ Lupus erythematosus	□ Shingles
□ Diabetes	□ High blood pressure	□ Pacemaker/defibrillator	□ Skin cancer
□ Endocrine disorders	□ Hirsutism	□ Polycystic ovary disease	□ Tattoos/Piercings
□ Filler injections	□ Hormone Replacement Therapy	□ Port-wine stain	□ Thyroid disease
□ Other		□ Precocious puberty	□ Vitiligo

Please answer the following questions:

Are you currently being treated for any medical condition?	□ Y	□ N	Explain: _____
Have you ever seen a physician regarding your skin?	□ Y	□ N	Explain: _____
Are you allergic to latex, lidocaine, or any lotions?	□ Y	□ N	
Do you have any skin allergies?	□ Y	□ N	Explain: _____
Have you had skin cancer or precancerous lesions?	□ Y	□ N	
Do you have psoriasis/eczema?	□ Y	□ N	
Have you/are you using Accutane?	□ Y	□ N	Date of last use: _____
Are you using Retin-A, Renova, Differin, Tazorac?	□ Y	□ N	Concentration: _____%
Do you smoke?	□ Y	□ N	
Do you sunbathe?	□ Y	□ N	If yes, approximate date of last sun exposure: _____
Do you use a sunscreen?	□ Y	□ N	Summer___ SPF_____ Winter___ SPF_____
Are you currently using a tanning bed or self-tanner?	□ Y	□ N	If yes, approximate date of last use: _____
Do you use facial depilatories? Hot wax?	□ Y	□ N	
Do you Keloid when healing from a cut?	□ Y	□ N	

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What skin care products are you currently using? (answer all that apply)

Cleanser: _____ Toner: _____

Serum: (anti-aging or acne)_____ Vitamin A: (Retinal/retinoid) _____

Vitamin C: _____ Eye cream: _____

Moisturizer: _____ Night cream: _____

Sunscreen: _____

Other: _____

Have you undergone any of the following cosmetic procedures:

Skin tightening procedure/treatment	□ Y	□ N	Treatment Name: _____	Area: _____	Date: _____
Resurfacing treatment	□ Y	□ N	Treatment Name: _____	Area: _____	Date: _____
Dermal filler (Juvederm/Radiesse)	□ Y	□ N	Treatment Name: _____	Area: _____	Date: _____
Neurotoxins (Botox/Xeomin)	□ Y	□ N	Treatment Name: _____	Area: _____	Date: _____
Facelift/Blepharoplasty/Brow lift	□ Y	□ N	Treatment Name: _____	Area: _____	Date: _____
Fat transfer	□ Y	□ N		Area: _____	Date: _____

I, (print name) _____, voluntarily consent to allow Dermabella Medical Spa, LLC to take photos of me before, during, and after treatments for **my** medical records and documentation purposes ONLY.

Int: _____ I confirm that the answers to the above questionnaire are true and correct, and that it is my obligation to inform DermaBella Medical Spa of any changes in my medical history and/or medications.

Int: _____ I understand that I will receive back this hard copy of my personal medical information along with the third page policies of DermaBella Medical Spa. This includes financial obligation on my part and responsibilities regarding treatment and appointment scheduling/cancellation.

A scanned copy of this paperwork is up-loaded into your medical file for future reference. If you need a copy at any time, please contact us.

If you have any questions or need assistance with any other matters relating to your membership, financial policy or treatment, please contact the Medical Spa Coordinator.

Call: 1-702-228-0491 **Text: 1-928-228-0491** **Email: Dermabellamedicalspa@gmail.com**

Signature of Patient: _____ Date: _____

Reviewed by Technician: _____ Date: _____

Reviewed by Medical Director: _____ Date: _____

DERMABELLA MEDICAL SPA FINANCIAL POLICIES AND INFORMATION COLLECTED

Because we provide elective cosmetic procedures, the care provided at Dermabella Medical Spa is not covered by any medical insurance programs, and we do not participate in any such plans.

Some of the content and medical spa services available in our location and on our website require registration. We may collect contact information (including name, phone number, mailing address, e-mail address, etc.). We may use this information to contact you if the need arises and to send you information about our company and promotional material. You always have the right to opt-out of receiving such mailings.

Your credit card information may be stored by our client management partner. Credit card transactions are handled by our payment processing partner. We reserve the right to change our client management partner or our payment processing partner at any time and without notice so you should check back with us regularly if this is a concern to you.

Int: _____ I understand that DermaBella Medical Spa reserves the right to use my credit card information given at time of booking to pay for my continuing or recurring memberships (per membership contract signed), no show/late arrival fees, and outstanding balances on my account.

REFUNDS FOR SERVICES PROVIDED

There are no refunds for products or services. Credit may be extended for other services to you or another individual. This is a case-by-case situation and will be handled by the Medical Director. Returns are not accepted for prescription products.
In the event that a package or series of treatments has begun, these services will be considered to have been rendered even though the full series may not have been completed. Should you wish to discontinue your treatment in the midst of a series, credit for the pro-rated share of unused treatments at the discounted package price *may* be extended, and this may be used to purchase other treatments or services offered by Dermabella Medical Spa, or it may be transferred to another individual to be used in exchange for treatments or services of comparable value to the credit.

PAYMENT OPTIONS

Payment for all medical spa procedures is due at the time of the treatment. For specially packaged or grouped treatments, payment for the entire package is due at the time of the first scheduled treatment. A credit card may be required to reserve an appointment for treatment scheduled in advance. A $50 charge (cash or credit card) may be due at the time of the booking to secure the appointment. This may be waived. We provide a number of payment options, Cash and debit cards along with Visa, Mastercard and Discover which may be used individually or combined. No personal checks are accepted.

REVISIONAL TREATMENT OR TREATMENT OF COMPLICATIONS

The practice of medicine and surgery is not an exact science, and medical spa treatments are the practice of medicine. Although good results are anticipated, there can be no guarantee or warranty, expressed or implied, by anyone as to the actual results you may get. Occasionally additional treatments and/or treatment for problems or complications may be required. These could result in additional charges for which you may be responsible.

CANCELLATION POLICY

We understand that situations may arise that could force you to cancel or postpone your treatment. Please understand that such changes affect not only our staff but our other patients as well, and we therefore request your courtesy and concern.

Dermabella Medical Spa requires a credit/debit card number to hold all appointments including consultations. In the event that you need to cancel your scheduled appointment with us, we require at least 24-hour notice. In the case of a same day cancellation, or if you fail to show up at your scheduled appointment time, you will be charged a $50 fee for your missed service. This is as a courtesy to our staff members who work hard to accommodate the needs of all of our patients.

LATE ARRIVALS

If you arrive 10 minutes after your scheduled appointment, the length of your treatment may be reduced at the end of your scheduled time, allowing the provider to take the next scheduled appointment on time.

Int: _____ I understand the above cancellation/no show and late arrival policy that is described above. I agree that I am subject to a $50.00 charge if I cancel less than 24hours, no show my scheduled appointment and/or arrive 10 minutes late.

Int: _____ I understand that Dermabella Medical Spa offers a courtesy appointment reminder call the day before my scheduled appointment but is not obligated to remind me of my scheduled appointment. It is my obligation to keep track of my appointments with the spa.

Int: _____ I understand that being called into work and/or stating that I "did not" receive a reminder call, or that you called but didn't leave a voicemail, does not negate the above policy and I will still be responsible for the charges stated above.

Int: _____ I understand that in the event I need to cancel my appointment I have 3 options to do so. **1.)** Call 1-702-228-0491 and leave a message on the voicemail. *The voicemail is time stamped for validation of 24-hour policy.* **2.)** Text 1-928-228-0491 with your message to cancel or reschedule. *You will receive back a confirmation of within normal business hours.* **3.)** Email to Dermabellamedicalspa@gmail.com with your cancellation request.

DMS recommends option #2 or 3 as proof of cancellation on your end in the event that both parties did not get the message.

I understand and agree to the terms and conditions of the above policy for DermaBella Medical Spa. I also understand the cancellation and financial policies are subject to change without notice.

Signature of Patient: _____ Date:_____

Reviewed by Technician: _____ Date:_____