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Patient Name _____ DOB_____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Cell (**REQUIRED**) (_____) _____Home (_____) _____Work (_____) _____

Primary contact number? (H) (C) (W) Sex: M ___ F____ Marital Status: S ___ M ___ W ___ D ___

Occupation _____ Employer _____

Emergency Contact _____ Relation _____ Phone (_____) _____

Email (**REQUIRED**) _____

Would you like to receive future monthly emails for promotional events, discounts, and specials from Eterna?
(Y) ___ (N) ____ Please Note: Cell phone and email are required for appointment reminders and will not be shared.

How did you hear about us? Internet ____ Friend ____ (Name) _____
Newspaper ____ TV ____ Radio ____ Billboard ____ Other (Please Specify) _____

Patients who cancel or reschedule with less than 24 hour notice, or who do not show for their scheduled appointment, may be charged a $50.00 fee to schedule their next appointment. This fee can be applied to treatments or procedures performed at the next appointment.

HEALTH INFORMATION

How is your general health? Fair ____ Good ____ Excellent ____ Height: ____ft ____in Weight: _____lbs

Primary Care Physician _____ Office Location _____

Which concerns apply to you? Please circle all that apply:

Acne	Black or Whiteheads	Brown Spots (Hyperpigmentation)	White Spots (Hypopigmentation)
Enlarged Pores	Oily Skin	Facial Veins	Rosacea
Uneven Skin Tone	Uneven Skin Texture	Lip Lines	Wrinkles
Loose Skin	Scars	Stretch Marks	Nail Fungus
Unwanted Hair	Unwanted Tattoo	Unwanted Body Fat	Hair Loss
Varicose Veins	Spider Veins	Hand Veins	Hemorrhoids
Rejuvenation of Intimate Areas		Other:_____	

Are you currently experiencing any unusual symptoms?
_____
_____

Have you been diagnosed with any medical problems?
_____
_____
_____

Have you had any major surgeries or hospitalizations? (include cosmetic surgeries)
_____
_____
_____

What medications, contraceptives, hormones or supplements do you take on a regular basis? (include OTC)

_____
_____
_____

Do you have any allergies to medications, latex, cosmetic ingredients or food? If yes, please specify and include the type of reaction and severity.

_____
_____

Are there any significant medical problems that run in the family?

_____
_____

Do you smoke? (Y) ____ (N) ____ If Yes, how many per day _____ How many years _____

Do you drink alcohol? (Y) ____ (N) ____ If Yes, how much _____ How often _____

Are you pregnant or trying to become pregnant? (Y) ____ (N) ____ Breastfeeding? (Y) ____ (N) ____

Pregnancies ____ # Live Births ____

Please complete this section if you are interested in:
SMARTLIPO / COOLSCULPTING / EXILIS

Height: ____ft ____in Current Weight: _____lbs Goal Weight: _____lbs ***OFFICE USE – BMI***: _____

What problem area(s) are you considering having treated? (Please circle area or areas)

Abdomen	Flanks (Muffin Top)	Inner Thighs	Outer Thighs
Double Chin	Arms	Upper Back (Bra Area)	Male Chest

Other _____

Tell us about your diet: _____
_____

Tell us about your exercise program: _____
_____

Have you ever had any of the following? (Check any that apply)

Adverse reaction to Lidocaine or Epinephrine___, Excessive bleeding following a procedure___, History of keloid scarring___, Body Dysmorphic Disorder___, Infectious Endocarditis___, MRSA (Methicillin Resistant Staph Aureus)___, Cryoglobulinemia___, Cold Agglutinin Syndrome___, Paroxysmal Cold Hemoglobinuria___

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Please complete this section if you are interested in: INJECTABLES / LASERS / SKIN CARE

What is your skin type? Dry _____ Oily _____ Normal _____ Combination _____

Do you have any of the following chronic skin disorders?

Acne Cold Sores/Fever Blisters/Sun Blisters Dermatitis Eczema
Genital Herpes Keloid Scarring Psoriasis Other_____

Have you ever undergone any of the following treatments?

Microdermabrasion Chemical Peel Dermaplaning Accutane

Are you currently removing hair by any of the following methods?

Laser Hair Removal Waxing Tweezing Nair type products Electrolysis

If so, when was it done and what area? _____
_____

Please list the products you currently use and the BRAND NAMES (if possible) of Cosmetic Products:

A.M.
Cleanser _____
Serum _____
Moisturizer _____
Eye Cream _____
Sunscreen _____

Other _____
Other _____

P.M.
Cleanser _____
Serum _____
Moisturizer _____
Eye Cream _____
Other _____

Other _____
Other _____

Have you ever had any of the following injectables or implants? (please circle)

Botox Dysport Juvederm Restylane Radiesse Sculptra
Bellafill/Artefill Kybella Other: _____

If so, when was it done and what area? _____
_____

Do you have any neuromuscular or autoimmune diseases? (Y) ____ (N) ____

List: _____

Do you have a fear of needles? (Y) ____ (N) ____

PATIENT'S SIGNATURE:

To the best of my knowledge, the information provided above is true and accurate.

Patient Signature _____ Date _____

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HIPAA - PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Eterna Vein & Medical Aesthetics may use and disclose **Protected Health Information (PHI)** about me to carry out **Treatment, Payment, and Healthcare Operations (TPO).** Please refer to Eterna Vein & Medical Aesthetics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Eterna Vein & Medical Aesthetics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Eterna Vein & Medical Aesthetics Privacy Officer at 1803 South Meridian Puyallup WA 98371.

With my consent, Eterna Vein & Medical Aesthetics may **call my home** or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO _____ **(initial)**. I also consent to **receive mailings** to my mailing address items such as appointment reminder cards and/or patient statements or any forms that are requested by patient and/or practice _____ **(initial)**. I also consent to **receive e-mail** to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements _____ **(initial)**.

With my consent, you may share any and all information regarding the care that I receive at Eterna with the following individual. **[ ] Check if same as Emergency Contact**

Name: _____ Contact #: _____ Relationship: _____

I have the right to request that Eterna Vein & Medical Aesthetics restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Eterna Vein & Medical Aesthetics use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent Eterna Vein & Medical Aesthetics may decline to provide treatment to me.

_____ _____
Patient's Signature Date

_____
Please Print Your Name