

Patient Information

Patient Name		DOB	
Social Security #			
Physical Address			
City		State	Zip Code
Mailing Address			
City		State	Zip Code
Phone Number	Home	Work	Cell
Contact person in case of emergency			
Phone Number			
How did you hear about us			
Email			
<p>Providing us with your email allows us to send occasional notices of monthly specials, promotions, and upcoming events here at Aistheta. We do not give or sell your information to anyone. It is for in-house purposes only. If you should choose to not participate please write none on the email line.</p>			
<p>Payment is due at time of service. Please note that these are elective cosmetic procedures, therefore we do not bill insurance. If you feel your insurance will pay for this procedure, we will provide you with billing information.</p>			
<p style="text-align: center;">Cancellation Policy</p>			
<p>We would appreciate at least 24 hours notice if you are unable to attend your scheduled appointment time. If notice is not given you may be charged for the missed appointment. A minimum of \$50 will be charged for the missed appointment. Considerations will be made for emergency situations. Thank you for your understanding.</p>			
Signature		Date	

Aistheta Reno Medical Skin Care Center

Robert J. Riley, M.D. / Libbie Morrow, P.A-C

6630 S. McCarran Blvd, Ste A-9

Reno, NV 89509

New Patient Profile & History Questionnaire

Name _____ DOB _____ Age _____ Sex F / M

In order to best serve your needs and personalize your care, please take a few moments to complete this form.

Primary reason for today's appointment: _____ How long have you had this problem? _____

Have a received treatment for this problem before today? Y / N If so, describe _____

Describe your skin (circle that apply) normal dry oily combination sensitive acne mature/wrinkled rosacea

acne-scarred freckled sun-damaged uneven tone surface capillaries dark spots light spots not sure

Please list your current medications: _____

Please list any allergies to medications: _____

Are you allergic/sensitive to (circle that apply) milk citrus grapes aloe vera aspirin perfumes latex
other _____

Are you sensitive to alcohol based products Y / N

Females: Are you pregnant? Y / N Currently taking birth control? Y / N Irregular Menstrual Cycle? Y / N

Do you wear contact lenses? Y / N Do you smoke? Y / N Do you wear orthodontic braces? Y / N

Do you frequently use tanning booths? Y / N If yes, how recently? _____ Average hours of daily sun exposure _____

Do you currently get facial waxing/ electrolysis / use depilatories? Y / N

Are you currently receiving microdermabrasion / chemical peels? Y / N If yes, how recently? _____

Do have regular filler and/or botox injections? Y / N If yes, what type of filler& last treatment date _____

Have you had facial surgery in the last 5 years? Y / N Have you had recent laser treatments? Y / N If so, type _____

What is your nationality? _____ Daily skin care routine? _____

Occupation _____

Do you have or have ever had any of the following?

- | | | | | | |
|------------|-------------|--------------------|---------------------|------------------|-------------------------|
| Anemia | Arthritis | Asthma/Hay fever | Bleeding disease | Cancer | Coronary Artery Disease |
| Cold sores | Diabetes | Eczema | Hair Loss | Heart Disease | Headaches |
| Hepatitis | HIV | Hives Hypertension | Keloids | Kidney Disease | Liver Disease |
| Melanoma | Lupus | Neurol. Disease | Peptic Ulcer | Previous Surgery | Psoriasis |
| Seizures | Skin Cancer | Tuberculosis | Recent WT gain/loss | | |

Signature: _____ Date _____

Technician Signature: _____ Pt Fitz Type _____ Date _____



RELEASE OF INFORMATION AUTHORIZATION

By signing this release, you are authorizing Robert J. Riley, M.D./Aistheta Reno Medical Skin Care Center to release your medical information to the individuals you have named below (spouse, a child, relative, friend). If you do not wish to have your medical information released to anyone but you, please fill in your name, sign and date the document.

I _____ (patient/parent/guardian) authorize Robert J. Riley, M.D./Aistheta Reno Medical Skin Care Center to release medical information for _____ (patient) to the following individuals:

1) _____
Name Relationship

Phone number

2) _____
Name Relationship

Phone number

3) _____
Name Relationship

Phone number

*This authorization may be revoked at any time with written notice.

Signature

Date

AISTHETA/ROBERT J. RILEY, M.D.

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice, or may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your Consent. Aistheta provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- Aistheta has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- Aistheta reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information but Aistheta does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- Aistheta may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by:

Printed Name – Patient or Representative

Signature

Date

Relationship to Patient (if other than patient)

Witness:

Printed Name – Practice Representative

Signature

Date