

LEHMAN ADVANCED DERMATOLOGY

MEDICAL. SURGICAL. COSMETIC

Date: ____/____/____

Patient Intake Form

Name: _____ Date of Birth: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Phone (____) _____ Email: _____

Billboard Clarksville Now Employee Facebook Google Search

Client: Name: _____ Other: _____

Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Primary Healthcare Provider: _____

Do we have permission to contact your primary care Provider? Yes No

Are you currently under the care of a medical or psychotherapist practitioner? Yes No

If YES, please explain: _____

List ALL current medications including aspirin, ibuprofen, herbal remedies, blood thinners, etc.: _____

Which concerns apply to you? (Check all that apply)

Uneven Skin Tone

Brown Spots (hyper pigmentation)

White Spots (hyper pigmentation)

Dry Patches

Enlarged Pores

Visible Exposed Blood Vessels

Hard Bumps Under Skin

Clogged Pores

Blackheads/whiteheads

Acne

Excessive oiliness

Skin Laxity

Upper Lip Lines

Wrinkles

Scarring

Unwanted Hair

Spider Veins

Rosacea (redness on face, neck or chest)

Stretch Marks

Cellulite

Unwanted Body Fat

Thinning Lashes

Other _____

What is your skin type: Dry Combination Oily Normal

Please check the products you currently use and the brand names:

Facial Cleanser

Moisturizer: _____ Toner: _____

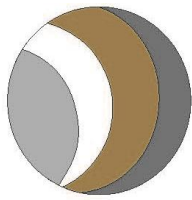
Serum: _____ Anti-Aging Serum: _____

Growth Factors

Sunscreen: _____ Retinol: _____

Eye Cream: _____ Antioxidant: _____

Scrub: _____



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Are you using any topical creams, lotions, or oral antibiotics for acne, skin cancer, anti-aging or hyper pigmentation? Yes No

If YES, Please list: _____

List all serious accidents, surgeries, aesthetic, laser, or massage therapy treatments:

Date: _____

Date: _____

Date: _____

Date: _____

Have you ever had any of the following injectables or implants:

Botox Juvederm Radiesse Restylane Perlane Silicone Hylaform
 Collagen Bellafill Sculptra Dysport Other _____

*If so, when was it done? _____ What Area? _____

*If so, when was it done? _____ What Area? _____

*If so, when was it done? _____ What Area? _____

Have you had any other cosmetic surgeries/procedures? Yes No

If YES, When? _____ Were you please with the results: Yes No

Please Mark any Conditions That Apply to You

Allergies to medications, food, latex, topical products or other substances

Please List: _____

Alpha Hydroxy Acid products in the last 48 hours

Rashes or Athletes Foot

Infections Photosensitizing medications

Polycystic Ovaries or menstrual dysfunction

Seizure History Pregnancy/nursing (Stage: _____)

Sun exposure in last 4 weeks

Herpes or cold sores

Accutane in last 12 months

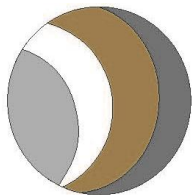
Retin A, Renova, salicylic acid, alpha/beta hydroxyl/glycolic products in the last 12 weeks

Myasthenia Gravis Guillain-Barre' Syndrome

Lambert-Eaton Syndrome

Other neurological conditions: _____

Thank you for taking the time to complete our Patient Intake Form. With the following information we will be better able to serve you. Our goal is to provide you with excellent service and results. At future visits, please let us know if any of the previous information changes. All information and treatments are confidential.



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Cancellation Policy

It would be greatly appreciated if appointments need to be cancelled, rescheduled, or the appointment type changed, that it be done at least 24 hours in advance. Should you fail to give us 24 hours notice to cancel or alter your appointment; a deposit for the full cost of future services will be required at the time of booking.

Initial that you have read and agree: _____

Children in the Spa

Due to the nature of our business as well as a safety precaution, we are **not able to accommodate children in the spa.**

Initial that you have read and agree: _____

I understand that the results are not guaranteed. There are many variables that are beyond our control that affect the procedure outcomes, especially individual expectations. We maintain our equipment and continue staff education and training regarding technique. There are times when the human body does not respond as well as we would like. Lifestyle choices, diet, exercise, hydration, prior skin damage, sun exposure and many other factors affect the final results. All of our patients are unique and have unique needs and expectations. Please discuss your treatment expectations with us prior to your treatment because **there are no refunds.**

Initial that you have read and agree: _____

Patient Consent for use and Disclosure of Protected Health Information

With my consent, Lehman Advanced Dermatology may use disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Lehman Advanced Dermatology's 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. Lehman Advanced Dermatology reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Lehman Advanced Dermatology, 781 Weatherly Drive, Suite C, Clarksville, TN 37043.

With my consent, Lehman Advanced Dermatology may call my home or other designated location and leave a message on my voice mail or in person in reference to any items to assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, among others unless otherwise indicated.

With my consent, Lehman Advanced Dermatology may send any items that assist the practice in carrying out our TPO, to my home or other designated location, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential, unless otherwise indicated.

By signing this form, I am consenting to Lehman Advanced Dermatology's 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, Lehman Advanced Dermatology may decline treatment for me.

Initial that you have read and agree: _____

Sign: _____

Date: _____

Print Name: _____