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: _____