The Aesthetic & Wellness Center
Restoring your health and beauty
5219 State Rd. 64 East, Bradenton, Fl | 941.749.0741

PATIENT INFORMATION FORM

Name: (Last) _____ (First) _____ (M.I.) _____ Sex: (M / F)
SSN (Required for Weight Loss Program):_____ Birth Date:_____ Age: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____
Best number to reach you: _____

E-mail appointment reminders: _____Yes _____No
Text message appointment reminders: _____ Yes _____No ****Cell # provider:** _____
E-Newsletter & Promotions: _____Yes _____No
Email: _____
(You will receive a welcome e-mail or text from us to confirm your appointment reminder preference)

Employment Information:
Employer: _____ Occupation:_____
Phone: ( ) _____ ext: _____
In Case of Emergency:
Name: _____ Relationship: _____ Phone: ( )_____

How did you hear about us?

- □ Magazine
- □ Physician Office
- □ Newsletter
- □ Referral by Current Patient
- □ Sign/Location
- □ Seminar
- □ Coupon Book
- □ Gyms
- □ Local Salon/Spa
- □ Radio advertising
- □ Television
- □ Internet Promotion
- □ Facebook
- □ Website
- □ Internet search

Financial Policy:
Please be advised that full payment for all services will be due at the time services are rendered. For your convenience we accept Visa, Master Card, Discover, Debit Card or Cash. We DO NOT accept personal checks.

No Show or Cancelled Appointment Policy:
We do not accept clients without appointments. Appointments that are not cancelled 24 hours prior to appointment time will be billed a $25.00 cancellation fee. Cancellation or no-show fees must be paid prior to making future appointments and are the sole responsibility of the client. Lipotropic injections missed cannot be credited for future injections. Repeat cancelled, or no-show appointments may result in termination from treatment at this practice.

Cancellation Policy
If you purchase an aesthetic treatment package and do not complete the series, your bill will be reconciled at the individual treatment rate and any resulting credit can be applied only to a gift certificate or to additional services or products. In regards to the Weight Loss Program, if you withdraw from the program, you will not be entitled to a refund of any previously paid monies.

My signature on this form confers the authorization for Medical treatment by Inda Mowett, MD and her staff at The Aesthetic & Wellness Center.

Signature: _____ Date: _____

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MEDICAL HISTORY

Name: _____ Age: _____ Birth date: _____
Today's Date: _____ Last Physical/Bloodwork: _____
Primary Physician's Name: _____
Office phone # (Primary Care Physician): _____

What is your reason for your visit today?
___ Cosmetic Services ____ Weight Management ____ Hormone Replacement Therapy

General Health History

___Autoimmune Deficiency
___Heart Attack
___Neurological Disease
___Eating Disorder
___Heart Disease
___Pacemaker
___Arthritis
___High Cholesterol
___Palpitations
___Asthma
___HIV/AIDS
___Psychiatric Care

___Bleeding Disorder
___Anemia
___Rheumatoid Fever
___Cancer
___Hypertension
___Skin Allergies
___Chemical Dependency
___Infection (active)
___Stroke
___Cold Sores/FeverBlisters
___Keloid Scar Formation
___Thyroid Disease

___Depression
___Kidney Disease
___Gout/Hyperuricemia
___Diabetes
___Liver Disease
___Emphysema/COPD
___Lung Disease
___Epilepsy/Seizures
___Migraine Headache
___Gastric Reflux
___Multiple Sclerosis
___Surgery
(Please list below)

Other: _____

Allergies

* Medications: _____
* Food: _____
* Cosmetics: _____
* Latex/Other: _____
* Are you allergic to?
  - □ Lidocaine □ Strawberries □ Collagen
  - □ Beef □ Eggs/ Chicken

Current medications

_____
_____
_____
_____
_____
_____

Social History

_____ Single _____ Married_____Widowed
Occupation:_____
Do you smoke cigarettes?_____
If yes, how many packs a day?_____
Do you drink alcohol?_____
If yes, weekly alcohol intake: _____

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Women only

Date of last menstrual period: _____
Are you pregnant? _____
Are trying to get pregnant? _____
Are you currently on hormone replacement? _
_____
Are you nursing? _____

Are you currently using contraception? _____
_____
If yes, please provide name of medications: __
_____
_____
_____

Family History

Check if any of your blood relatives have had any of the following:
__ None __ Cancer __ Diabetes __ Heart Disease __ Stroke __ Kidney Disease
__ Obesity __ High Blood Pressure Other: _____

History of previous cosmetic treatments or procedures:

□ Ablative Laser
□ Laser Acne Treatments
□ Botox
□ Laser/IPL Hair Removal
□ Cellulite Reduction
□ Chemical Peels
□ Microdermabrasion
□ Dermal Fillers
□ Permanent Make-Up
□ IPL Fotofacial
□ Skin Tightening

When did you have it done? _____

Are you currently taking/using?

__ Retin-A __ Renova __ Steroids ___ Prescription acne medication
Have you been taking Accutane for the past 12 months? _____
What line of skin products are you using? _____
_____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

_____ _____
Print Name, Parent or Legal guardian Date

_____ _____
Signature Reviewed by/ Date

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What procedures are you interested in?

Check all that apply

Treatment sun damaged skin (brown spots)
___ Face
___ Neck
___ Chest
___ Hands
___ Arms/forearms
___ Legs

Removal of fine lines and wrinkles
___ Full face
___ Forehead
___ Crow's feet
___ Lower face
___ Neck
___ Face and neck

Facial veins/Broken Capillaries/Rosacea
___ Full face
___ Mid-face
___ Nose/Cheeks
___ Lower face

Skin Care Services (other)
___ Microdermabrasion
___ Chemical Peels
___ Micro-Needling
___ Skin Rejuvenation
___ Hand Rejuvenation
___Double chin/Jowls/Eye Fat pads
___Aesthetic VIP Membership

Wellness Testing
___ Metabolic Testing & Evaluation
___ Nutritional Testing & Evaluation
___ Food Sensitivities Testing & Evaluation

Medical Fitness
___Private Fitness Session
___Group Training Classes
___Pre-Natal Exercises
___Yoga Classes

Injectable Fillers (Juvederm/Restylane/Radiesse)
___ Lip augmentation
___ Smile lines
___ Marionette's lines
___ Smoker's lines
___ Volume correction-cheeks/mid- face
___ Lower lids/sunken eyes

Pulsed Light Hair Removal
___ Neck
___ Back
___ Chest
___ Abdomen
___ Underarms
___ Forearms
___ Upper arms
___ Beard (male)
___ Bikini Line
___ Full leg
___ Half Leg
___ Upper lip/chin

Botox
___ Frown lines
___ Forehead lines
___ Crow's feet
___ Smoker's lines
___ Nose lines
___ Neck bands/wrinkles

Hormone Replacement Therapy
___ Hormonal imbalance
___ PMS
___ Pre-menopause
___ Menopause
___ Post-menopause
___ Thyroid Disease
___ Low Testosterone

___**Weight Loss Management**
___ **Therapeutic Massage**

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SKIN PHOTOTYPE TEST
FITZPATRICK CLASSIFICATION

Name: _____ Date:_____

Please circle the one that describes your skin type:

A. Type I: Always burns, never tans. Red or blonde hair, light eyes.

B. Type II: Burns easily, tans minimally. Blond hair, light eyes.

C. Type III: Sometimes burns, tans gradually and uniformly. Brown hair, blue/hazel eyes.

D. Type IV: Rarely burns, almost always tans well, also known as "olive" complexion. Brown hair, brown eyes. Most light- skinned Blacks, Latinos, and Asians.

E. **Type V:** Rarely burns, tans profusely. Most medium Blacks, Latinos, and Asians.

F. Type VI: Never burns; tans profusely, deeply. Most dark-skinned Blacks.

What is your natural hair color?_____

What is your eye color?_____

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Photography consent

I, _____hereby authorize Dr. Inda Mowett or any member of her staff to take before and after picture(s) of the skin treatment, procedure or weight loss program I am receiving. These photograph(s) may be used for my file and only portions of my face or body will be placed in photo albums or slide presentations to show the results of my treatments.

_____ _____

Print Name Sign Name

_____

Date

If the above person is a minor (Under the age of 18), the signature of a parent or guardian is required below;

_____ _____

Print name of Parent or Guardian Signature of Parent or Guardian

_____

Date

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Patient Consent: Message and/or Appointment Reminders Per HIPAA Regulations

Today's Date _____
Patient Name:_____DOB:_____

May we leave the following types of messages at your home, work, cell phone number, personal email or:

1.	Office appointment reminders/changes	Yes	No
2.	Labs and/or outpatient test results	Yes	No
3.	Payment requirements for upcoming appointments	Yes	No
4.	When authorization, medical records, other info needed	Yes	No
5.	Prescription refill information	Yes	No
6.	Receive office emails to my personal email account	Yes	No
7.	Receive my before and after photos to my personal email account	Yes	No

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Acknowledgement of Receipt of Notice

As required by the privacy regulation, I hereby acknowledge that I have received a current copy of the privacy notice. You can find a copy of HIPPA form at our website wwww.tawcenter.com under office forms tab. I understand that is my responsibility to read through the given information, make any requests and provide documentation that may protect my confidentiality within this practice.

By way of signature, I provide Inda Mowett, MD with my authorization and consent to use and disclose my healthcare information for the purposes of treatment, payment and healthcare described in the privacy policies.

_____
Signature & Date

My healthcare information may be shared with the following persons:

_____
Name & relationship to patient

_____
Name & relationship to patient

No, my records may not be shared _____

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Attendance and Cancellation/No Show Policy

Dear Valued Patient/Client:

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are in effect for recurrent tardiness and missed appointments

- **24 hour advance notice** is required when cancelling an appointment. This allows for someone else to schedule an appointment during that time. If you are unable to give us 24 hours advance notice you will be charged $25 for your missed appointment, including voicemails left with l**ess** than 24hour notice. This amount must be paid prior to your next scheduled appointment or charged to your credit card on file.

- **Payment Method** - Visa, MasterCard, Discover, American Express and cash. Checks are not accepted.

- **No-shows**
  Anyone who either forgets or consciously chooses to miss their scheduled appointment for any reason will be considered a "no-show." They will be charged $25 for their "missed" appointment.

- **Late Arrivals**
  If you arrive late, your session will be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your appointment may to be rescheduled. Regardless of the length of the treatment actually given, **you will be responsible for the payment of the "full" session**. **Please** plan accordingly and be punctual.

- **No Refunds**
  No refunds will be issued for deposits made if cancellation was not received within 24 hours before scheduled appointment. There will be no refunds provided for unused portions of a weight loss program. Medication and lipo injections are also non-refundable and non-transferable

- **Pre-paid cycles**
  Weight loss patients who have pre-paid for a cycle and have to cancel with notice a scheduled appointment will receive credit towards the next month's payment. Unused weeks will be reconciled at the weekly rate

Sincerely,

Inda Mowett, MD

By signing below, I authorize TAWC to charge the account $25 for cancelling or no show for my schedule appointment. I understand that TAWC may continue to charge my account if time after scheduling an appointment I do not notify the office 24 hour prior to my visit. Or cancel my membership in accordance to the terms, rules, regulations and conditions of this agreement. Additionally, I authorize TAWC to charge my credit/debit card on file in lieu of receiving additional services, at my request. You acknowledge receiving and reading a copy of this agreement.

I hereby authorize TAWC to keep swiped credit card information on file and to charge this card if necessary in accordance with the terms of this agreement.

_____ _____
Print Name Date

_____ _____
Signature Date

R. 12/17