New Patient Intake Form

Today's Date: _____

Client Demographics

Client's Name: _____ DOB: _____ Age: _____ Gender: □ M □ F

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

Home / Mobile: _____ Work: _____

Would you like Text reminders? □ Yes □ No If Yes, list your Phone Carrier: _____

Would you like to receive newsletters regarding our specials and discounts on services and products? □ Yes □ No

Please list your email: _____ Would you like email reminders for appointments? □Yes □No

Occupation: _____

How did you hear about us? _____

Who may we thank for referring you? _____

What is the reason for your visit? _____

Emergency Contact

Name: _____ Relationship: _____

Home / Mobile: _____ Work: _____

In case of emergency, are we able to release medical information regarding your case to the listed contact above? □ Yes □ No

Please check off all services that are of interest to you

□ Acne/Rosacea
□ Light Therapy
□ Aesthetics (Skin Care)
□ Anti-Aging
□ Skin Tightening
□ Wrinkle Reduction
□ Botox
□ Filler
□ Hair Regeneration
□ Laser Hair Removal
□ Laser Treatments
□ Micro-needling
□ Light Therapy
□ Medical Weight Loss
□ Vaginal Rejuvenation
□ Sexual Enhancement
□ Women's Health
□ Bio-Identical Hormones
□ Body Sculpting
□ Weight Management
□ Eyelash Growth

□ Urinary incontinence, dryness, painful sex, laxity

Medical History

Please check the following that pertain to your present health / past medical history:

□ Allergies/Sensitivities
□ Artificial Joint
□ Atherosclerosis
□ Bruise Easily
□ Cancer
□ Carpal Tunnel Syndrome
□ Contagious Skin Condition
□ Anemia
□ Frequent Colds & Flu
□ Deep Vein Thrombosis/Blood Clots
□ Diabetes
□ Epilepsy
□ Headaches/Migraines
□ Heart Condition
□ Hemophilia
□ Rheumatoid Arthritis
□ Open Sores/Wounds
□ Nervous Disorders
□ Pregnancy - Months? _____
□ Phlebitis
□ Shortness of Breath
□ High/Low Blood Pressure
□ Hepatitis
□ Kidney Disease
□ Sprains/Strains
□ Swollen Glands
□ Thyroid Problems
□ Osteoporosis
□ Tuberculosis
□ Fibromyalgia
□ Hearing Aid
□ High Fevers
□ Asthma
□ Allergies/Sensitivities
□ Stroke
□ Keloid Scars
□ Mental Illness
□ Acutane
□ TMJ
□ Claustrophobia
□ Herpes Outbreaks
□ Vein Problems
□ High Cholesterol
□ Arthritis
□ Nervous Disorders
□ HIV
□ Insomnia
□ Multiple Sclerosis
□ Obesity
□ Acne
□ Latex Allergy
□ High Fevers
□ Contact Lenses
□ Dermatitis/Eczema
□ Frequent Sinus Infections
□ Pacemaker
□ Skin Rashes
□ Other_____

Skincare Intake Form

Name:_____

Briefly describe your skincare regimen and products you are currently using:_____

Please circle if you have recently used any of the following Medications:

Adapalene Airol Altinac Ziana Antibiotics Anti-Histaines Anti-Inflammatories Avage Avita
Benzac AC Brevoxyl Differin Epiduo Glycolic Acid/Alpha hydroxys Hydroquinone Isotred
Isotrexin Metrogel Obagi Nuderm tretinoin Retin A micro Retin A/renova Roaccutane Stieva-A
Stievimycin Tazorac Tetrieve tm Tretin x Tretinoin Tri-luma Vitamin C Zorac

Any other medications not listed above?_____
(**This is not a complete representation of all the retinoids/topical medications available; however please answer to the best of your ability.)*

Have you taken any ORAL Medications listed below with the last 12 months? Yes No

Accutane Claravus sotret Roacutane Amnesteen

Please list any other medications that are not listed above:_____

Have you had any of the following: (Circle)

Dermatitis Chemical Peels Facial Implants Glycolic Acid/Alpha Hydroxys Keloid Scarring

Laser Resurfacing Major Sugery/Cosmetic Procedure Skin Cancer Tattoos/Permanent Makeup

Other: (please specify):_____

Do you have any known allergies to the following: (Circle)

Aspirin Fruits (papaya, pineapple) Milk Shellfish

What areas are you looking to improve? (Circle)

Acne Acne Scarring Burns or/scars Enlarged Pores Fine Lines and Wrinkles Vitiligo

Hyperpigmentation (brown spots) Melanoma/Moles Stretch Marks

Other:_____

Skin Type: (Circle) Dry Normal Oily Combination

Specific Skin Concerns: (Circle)

Blackheads/Whiteheads Broken Capillaries Burns/Scars Congested Pores Diffused Redness

Discomfort Eczema Enlarged Pores Excessive Dryness Ingrown Hairs Itchiness Lack Firmness

Oily Psoriasis Razor Bumps Reactive Skin Redden Easily Sensitive

Other:_____

Hyperpigmentation Causes: (Circle)

Acne lesions Antibiotics Birth Cotrol Pills Picking Pregnancy Sun Exposure

How long have you had hyperpigmentation condition:_____

Do you use skin lighteners? (Hydroquinone) Yes No

Do you use sunscreen? Yes No

Do you sunbathe or participate in other outdoor activities? Yes No

Skin Texture: (Circle) Coarse Thin Thick Wrinkles

Skin Deterioration: Brown Spots Fine Lines Furrows Wrinkles

Acne Conditions: Do you have acne or are currently being treated for this condition? Yes No

If yes, which condition: Comedones Cysts Milia Nodules Papules Pustules

Skincare History

Are you currently or have ever used medications for acne? Yes No

Have you seen a Dermatologist with the past year? Yes No

Have you ever had Herpes (cold sores)? Yes No

Have you ever been treated with Zovirax TM/Valtrax TM or any Herpes medication? Yes No

Do you have Epilepsy or Diabetes? Yes No

Are you presently under a physician's care for any reason? Yes No

Do you use Biore or Snore Strips? Yes No

Do you take nutritional supplements? Yes No

Have you had any facial waxing or electrolysis in the past week? Yes No

Have you ever been treated by an Endocrinologist? Yes No

Do you drink alcohol? Yes No

Are you a smoker? If yes, approximately how many per day? Yes No

Female Clients Only:

Are you on hormone replacement therapy?

Are you presently taking birth control pills?

Are you pregnant or planning to be?

Do you have/had Polycystic Ovarian Syndrome?

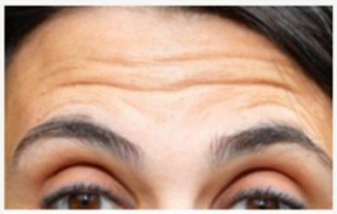
Do you have Hirsutism?

When was your last Menstrual Cycle?_____

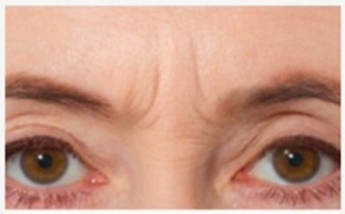
NAME:
AGE:
DATE:

PLEASE INDICATE ANY AREAS OF CONCERN FOR YOU

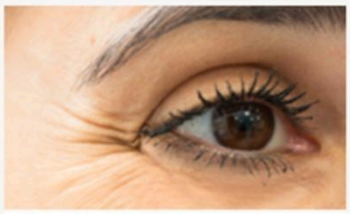
CHECK ALL THAT APPLY



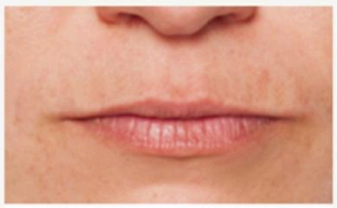
☐ FOREHEAD LINES



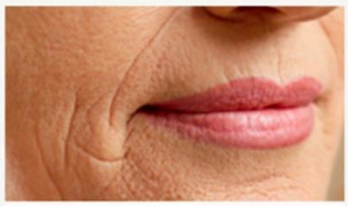
☐ FROWN LINES



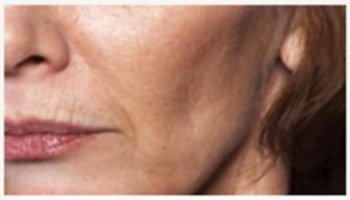
☐ CROW'S FEET



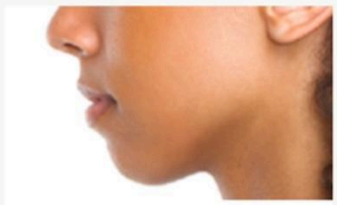
☐ THIN LIPS
LIP TEXTURE



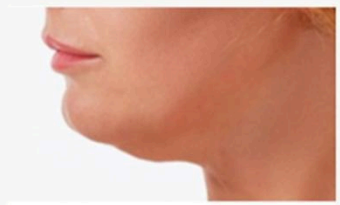
☐ LINES/WRINKLES
AROUND NOSE AND MOUTH



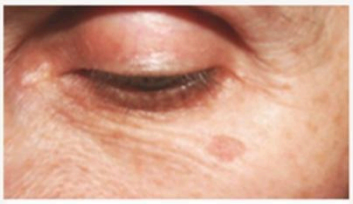
☐ SUNKEN/
SAGGING CHEEKS



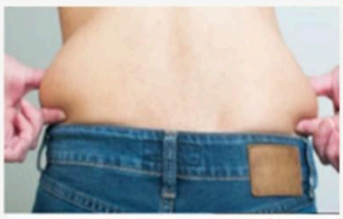
☐ SMALL/WEAK
CHIN PROFILE



☐ DOUBLE CHIN

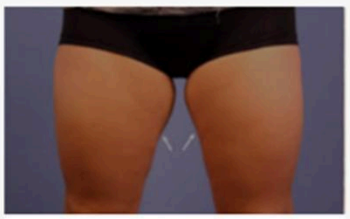


☐ SKIN APPEARNACE
AND TEXTURE



☐ "LOVE HANDLES"
OR BELLY FAT

☐ STUBBORN ARM FAT



☐ INNER THIGH POCKET

SHARE HOW YOU SEE YOURSELF

- o I feel I look tired
- o I feel I look sad
- o I feel I look angry
- o I feel I have saggy skin
- o I feel I look older than my age
- o I feel I don't look contoured
- o I feel I don't look smooth
- o I feel I dont look aesthetically pleasing

Medical Information Release Form

(HIPAA Release Form)

Name:_____ Date of Birth: _____

Release of Information

( ) I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

( ) Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call _____

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

( ) _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

Cancellation and No-Show Policy

Our goal is to provide quality service in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our clients who are on a wait list.

Cancellation of an Appointment

In order to be respectful of the needs of other clients, please be courteous and call Renu Laser and Skin Care promptly if you are unable to show up for an appointment. This time will be reallocated to someone who would like a treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to this time availability.

How to Cancel Your Appointment

To cancel appointments, please call 303-470-0200. If you do not reach the receptionist, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations:

A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice.

No Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

I,_____have read and fully understand the above statements.

WE ASK THAT YOU PROVIDE US WITH 24 HOURS NOTICE OF CANCELLATION FOR ANY APPOINTMENTS. WE RESERVE THE RIGHT TO CHARGE A $50 FEE FOR ANY APPOINTMENTS THAT ARE MISSED WITHOUT NOTICE.

FINANCIAL POLICY

Please review and initial next to each of the following to acknowledge that you understand and accept each of the listed policies by Renu Laser and Skin Care.

_____PAYMENT DUE TIME OF SERVICE: Forms of payment acceptable; all major Credit Cards, Cash, Checks, or Care Credit. Once payment, or a portion of payment, has been received for services there will be no monies returned , under any circumstances.

_____RETURNED CHECKS: $50.00 fee added to all returned checks.

My signature below indicates that I have read and agree to the terms set above.

I,_____have read and fully understand the above statements.

All questions pertaining to my care at Renu Laser and Skin Care have been answered to my complete satisfaction. I have read and understand these terms of acceptance, and agree to abide by them.

I therefore accept treatment of service that’s provided by Renu Laser and Skin Care on this basis

Information

This clinic complies with the rules and regulation promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of all tools, needles and sanitation. The practice of Weight Loss Management and Esthetics are regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. They can be contacted by telephone at 303.894.2440 if you have any questions, comments or concerns.

Please ask or refer to Renu Laser and Skin Care to review our provider's biographics/credentials.

Renu Laser and Skin Care at 1420 W. Canal Ct., Suite 180, Littleton, CO 80120

Medical Director:	Dr. Michael Iannotti, MD	303-929-9771
Owner:	Lynn Beswick	303-919-9142
Nurse Practitioner:	Ashley DeGrush, FNP	303-718-6899
RN:	Abby Coggins	
Medical Aesthetician:	Lynn Beswick and Brittany Johnson	