New Patient
Medical History Form

Name:____**Date of birth:**______________**Today's Date:**______________

Address:____ **City:**____________________ **State:** _______ **Zip:**____________

Age:________ **Sex:**________ **Height:**________ **Weight:**________ **Emergency Contact:**______________**Phone** #:_____________

Home #:___________________**Cell #:**_______________________ **E-mail:**____

How did you hear about us and/or who referred you?____

Reason for today's visit:____

Have you ever had any of the following conditions? (Check all that apply)

□ cold sores	□ allergy/hay fever	□ dizziness/fainting spells	□ epilepsy
□ skin rash/disease	□ asthma or wheezing	□ head injury	□ eye injury or disease
□ heart trouble	□ shortness of breath	□ neuritis (nerve inflammation)	□ swollen/painful joints
□ cancer	□ tuberculosis	□ mitral valve prolapse	□ rheumatism/arthritis
□ diabetes	□ AIDS/ARC	□ drug or alcohol addiction	□ tendonitis
□ high blood pressure	□ nervousness / anxiety	□ frequent severe headaches	□ ankle/feet swelling
□ bleeding problems	□ back problem/pain	□ phlebitis of veins	□varicose veins

□ Other:____

List all hospitalizations for illnesses, operations, accidents or fractures:____

____

Medications:____

____

Have you ever taken Accutane? □ Yes □ No **If yes, date stopped:**_______________________________________

Allergies:____

____

Do you drink alcohol? □ Never □ Occasionally □ 1-2 drink per week □ 3-5 drinks per week □ 5+ drinks per week

Do you smoke? □ Never □ Occasionally □ Current every day smoker □ Former smoker

When you go to the dentist: Do you require antibiotics to be used? □ Yes □ No **Extra numbing medication?** □ Yes □ No

Primary Physician (Name/Telephone):___________________________________ **Pharmacy Phone:**______________________

Women only: Are you pregnant or trying to become pregnant? □ Yes □ No **Are you breastfeeding?** □ Yes □ No

Are you currently under the care of a dermatologist? □ Yes □ No **If yes, list reason:**______________________________

Which of the following best describes your skin type: (Check which applies best)

□ **I** Very Fair - Always burns, cannot tan	□ **II** Fair - Usually burns, sometimes tans	□ **III** Medium - Sometimes burns, usually tans
□ **IV** Olive - Rarely burns, always tans	□ **V** Brown - Never burns, always tans	□ **VI** Dark brown – Never burns, always tans

Have you used any products that caused a bad reaction or have experienced a skin allergy/sensitivity ? □ Yes □ No

If yes, describe:____

Which non-surgical cosmetic procedures have you previously had? (Check all that apply)

□ BOTOX	□ Fraxel	□ ThermiVa/Vaginal Rejuvenation	□ Sculptra
□ Dermal Fillers	□ Microneedling/ Vampire Facial	□ ThermiSmooth	□ Facial
□ CoolSculpting	□ IPL Photofacial	□ Hair Restoration	□ Microdermabrasion
□ Ultherapy	□ Laser Hair Removal	□ Kybella	□ Chemical Peel
□ Other:______________________________			

What are your aesthetic goals or desired improvements? ________________________________

____

Greenwich Medical Spa Policies

Reservations: We encourage you to arrive 15 minutes prior to your appointment so that you may relax, enjoy a gourmet beverage, change and fill out the appropriate forms. It is our top priority to insure we take you at your scheduled appointment time. If you arrive more than 15 minutes late, we may have to reschedule your appointment in fairness to our other patients.

Cancellations: All appointments must be secured with a credit card. We require a 24-hour notice to reschedule or cancel your appointment, and a 48-hour cancellation notice for Ultherapy and CoolSculpting procedures. A cancellation or no-show fee of $75 is charged if you cancel or reschedule your appointment within 24 hours.

Deposits: For some procedures that require a significant amount of time to perform, we require a $300-$500 deposit to make the appointment. We require a 48-hour notice to reschedule the appointment. If the appointment is rescheduled within 48 - 24 hours, you will lose 50% of your deposit, if the appointment is rescheduled or canceled in less than 24 hours, **you will lose 100% of your deposit.**

Series Purchases: All packages and series expire 2 years after the date of purchase. Series are non-refundable and non-transferable.

Gift Certificates: Gift Certificates can be purchased in any amount at both of our locations or online, and do not expire. They may be redeemed for services, series or products. There are no refunds on gift certificates. Greenwich Medical Spa is not responsible for lost gift certificates and lost gift certificates will not be replaced.

Amenities: For your comfort, robes, slippers and wraps are provided during your visit. Special attention to your privacy, comfort and relaxation are observed.

Payments: We accept Cash, MasterCard, Visa, Discover, American Express and Gift Certificates. ***WE DO NOT ACCEPT CHECKS.*** You can also finance your treatment with our Cosmetic Payment Plan: CareCredit. Payments must be made in full for all services and series.

Returns: No refunds on services, series, gift certificates, deposits and opened products. Unopened products may be returned within 7 days. If you no longer wish to use your deposit towards your treatment, it will become a spa credit which you can use towards other services and products.

Our prices are subject to change without notice. Above policies also available on our website at:
www.greewichmedicalspa.com/policies

***Patient Consent*:** I certify that I have read and understand the above.

Patient Name:______________________ **Signature/Date:**______________________

HIPAA Notice and Acknowledgement of Privacy Policy and Procedures

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), The Greenwich Medical Spa may not use or disclose your personal health information without your authorization.

THIS PRACTICE HAS POLICIES AND PROCEDURES TO COMPLY WITH HIPAA LAW. EVERY ATTEMPT HAS BEEN MADE TO KEEP THE PROCESS FOR PATIENTS AND STAFF AS EFFICIENT AS POSSIBLE. HOWEVER, THE REQUIREMENTS ARE EXTENSIVE AND TAKE TIME, EFFORT AND COOPERATION TO PROCESS REQUIRED TASKS.

All patients are presented with certain notices and must sign certain forms. Depending on the course of treatment, some patients may be required to sign additional forms. The following is a summary of the most common notices and forms:

Notice of Privacy Practices: This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Authorization for Use or Disclosure of Protected Health Information: The Practice may not use or disclose your health information for purposes other than treatment, payment or health care operations, without your authorization. Your signature on this form indicates that you are giving permission to the people listed on the form, for the use and disclosure of the health information listed on the form, for the purposes on the form, to the people/organizations listed on the form. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

Complaint: You have the right to complain about the Practice's privacy policies, procedures or actions. The Practice will not engage in any discriminatory or other retaliatory behavior against you because of a complaint.

Request to Amend Protected Health Information: You have the right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. The Practice will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures.

Request for Inspection of Protected Health Information: You have the right to request the opportunity to inspect and copy health information that pertains to you. The Practice will evaluate your request and will either grant it or explain the reason why the request will not be granted. In the event that your inspection request is not granted, you may request that the decision be reviewed by someone other than the person who denied the request.

Request for Accounting of Disclosures of Protected Health Information: You have a right to request an accounting of disclosures of health information that pertains to you.

Confidential Channel Communications Request: You have the right to request that communications concerning your personal health information be made through confidential channels. The Practice will do its best to accommodate all reasonable requests. Designation of Personal Representative: You have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By making this request, you are informing the Practice of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Acknowledgement of Receipt of Notice of Privacy Practices: I acknowledge that I have received and read the above Notice of Privacy Policy and Procedures and that I have had any questions regarding this notice answered to my satisfaction.

Patient Name: ____ **Signature/Date:** ____