

Vitality Medispa and Medical Clinic

New Patient Information

Name: _____ Birth Date: ____ / ____ / ____ Age: _____

Address: _____ Sex: M / F

City: _____ State: _____ Zip Code: _____

Home: (____) _____ Cell: (____) _____

E-mail: _____

Emergency Contact: _____ Telephone: (____) _____

Do we have permission to leave a detailed message on your phone if needed? Yes No

How did you hear about Vitality MediSpa & Medical Clinic?

Google or web CitySearch Yelp Walked by/local Banner Outside Radio Ad
 Current customer: _____ Employee of Vitality: _____
 Physician Referral: _____ Gift Certificate Other: _____

GENERAL INFORMATION:

Who may we thank for referring you? _____

Occupation: _____ How much water do you consume daily _____

List all medication allergies

SKIN TYPE/BACKGROUND: Please circle the skin type that describes you the closest:

Skin Type 1 - Very fair, always burn never tans

Skin Type 2 - Fair, Always burns, sometimes tans with difficulty

Skin Type 3 - Fair to light olive, sometimes burns mildly, tans slowly

Skin Type 4 - Olive to light brown, Rarely burns, tans easily

Skin Type 5 - Dark Brown, Very Rarely burns, always tans

Skin Type 6 - Black, never burn, always tans

MEDICATION: check all that you are currently taking or have taken within the past year

ANTIVIRAL MEDICATIONS RETINOIDS ACCUTANE STEROIDS ANTIBIOTICS

ASPIRIN/BLOOD THINNERS BIRTH CONTROL/HORMONE REPLACEMENT

CHLOROQUIN/HYDROXYCHLOROQUIN

IMMUNOSUPPRESSANT HYDROQUINONE ANTI-DEPRESSANTS

List any additional medications or herbal supplements you are currently taking or have taken in the last year:

MEDICAL HISTORY AND/OR ILLNESSES:

DIABETES COLD SORES / HERPES SIMPLEX VIRUS VASCULAR DISEASE

MELANOMA POLYCYSTIC OVARIAN SYNDROME VITILIGO THYROID HORMONE

DEFICIENCY HIGH BLOOD PRESSURE METAL IMPLANTS EPILEPSY CANCER

RADIATION/CHEMOTHERAPY HEART PROBLEMS AUTOIMMUNE PREGNANT OR

NURSING HEPATITIS KELOID/SCARRING SEIZURES STROKE

OTHER _____

AESTHETIC/WELLNESS HISTORY: Please check off any treatments you have had/tried in the past:

BOTOX DERMAL FILLERS (RESTYLANE/JUVEDERM ETC) PEELS LASER

ELECTROLYSIS FACELIFT/LID SURGERY HORMONE REPLACEMENT ACUPUNCTURE

LIPOSUCTION FACIALS WAXING

Vitality Medispa & Medical Clinic

Tami S Meraglia, M. D

Notice of Privacy Policy

Understanding Your Health Information:

A record of your visit is made each time you come to our facility. This record may contain personal, identifying information about you, your health, and treatments here at Vitality. This information is needed for the following purposes:

- A record for planning your care and treatment
- Legal documentation describing the care you receive
- To help technicians/physicians make decisions about your care

Your Health Information Rights:

Your records are confidential and you have the right to:

- Request that we limit certain uses and releases of your information
- Request that you get a copy and are allowed to see your records
- Request that any or all communications of your health information be made by different means or to a different location

Our Responsibilities:

We are required to:

- Protect the privacy of your information
- Respect reasonable requests to communicate health information by different means or to different locations

Acknowledgement of Receipt:

By signing this form, I acknowledge that I have received a copy of Vitality Medispa & Medical Clinic "Notice of Privacy" practices:

I authorize disclosure of my protected health information to the person(s) indicated below:

- Spouse only _____
Print name
- My immediate family _____
Print name (s)
- Other _____
Print name (s)

Patient Signature

Date

Vitality Medispa & Medical Clinic

Tami S Meraglia, M. D

Photograph Usage Consent Form

Option A

I consent to the taking of photographs prior to, during, and after my cosmetic procedure.

I understand that regardless of how my photos are used, my name and/or other personal information about me will NOT be used in any material or ever be published.

I give Vitality the right to use, reproduce, and distribute my photograph for marketing purposes so long as I am made aware of where the images will be used an how.

Y N _____
Initial

I allow Vitality to use my photos for medical seminars and/or for educational and research purposes.

Y N _____
Initial

I may revoke this authorization at anytime by providing a notice in writing to Vitality Medispa & Medical Clinic.

Patient Signature Date

Option B

I authorize the taking of my photographs solely for documentation of my medical chart with Vitality Medispa and Wellness Center.

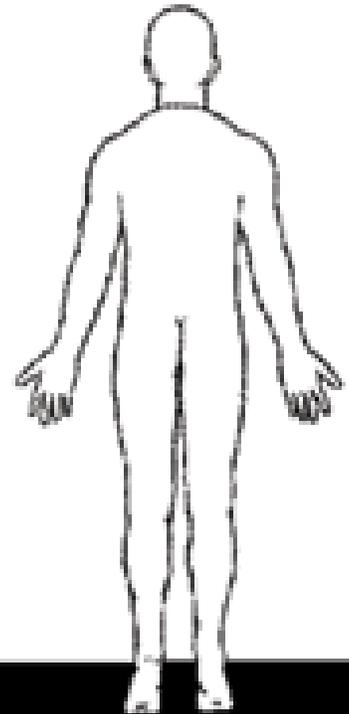
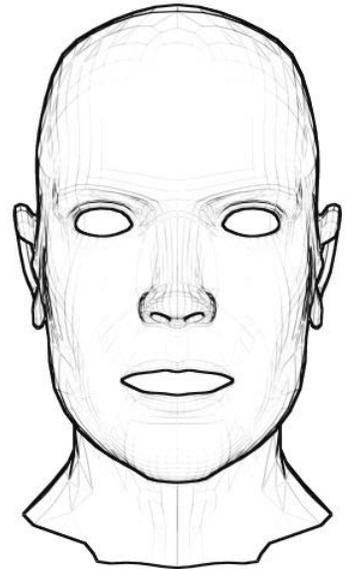
Patient Signature Date

Self Assessment

√	Check any that apply to you:
	Sun damage/Brown spots
	Lines & Wrinkles
	Loss of Volume/Tired looking
	Sagging skin
	Under eye circles/wrinkles
	Veins on face and/or legs
	Dull, lifeless skin
	Acne
	Rosacea
	Melasma
	Broken Capillaries
	Scarring
	Tired of shaving/razor bumps
	Thin Lips
	Cellulite
	Trouble sleeping
	Weight Issues
	Fatigue
	Hot Flashes/ Mood swings
	Nutritional Concerns/Digestion problems
	Fertility
	Tired of putting make-up on

One of our main goals at Vitality is to **LISTEN** to you and truly understand why it is you are coming to us for care. Please help us understand your needs by completing this self assessment of the ‘problems’ or ‘concerns’ you may have.

Draw on or mark any areas of your face and/or body that concern you:



Front

Back