Patient Medical History

Name: ___________________________________Date: _________________ DOB_______/_______/_______

Address___________________________________City__________________State_________Zip_______________

Phone: (Home) ____________________ (Work) _________________Ext.___________ (Cell) _________________

Preferred Method of Contact (Please Circle): Home/Work/ Cell Occupation: ___________________________

Email Address: _____________________________________ Would you like to receive coupons for services: YES/NO

Emergency Contact: Name_______________________ Phone #___________________ Relationship_____________

Pharmacy name and location: ____ Phone: ____________________

What Medications are your current medications? ____

Any known drug or food Allergies: ____

Current Products Using: ____

Do you use Glycolic products, exfoliating products, or Retin-A? (Yes/No) If yes, please list products:

____Last used: _______________________

HOW DID YOU HEAR ABOUT US? Please list their name as they qualify for a $10 referral credit!

Client / Employee Name: ____

Facebook _______ Instagram _______ Twitter ______ Yelp _______ Google __________________________

Mail______ Internet_______ Word-of-Mouth_____ Walk-In________ Other ___________________________

PLEASE CIRCLE YES OR NO

Are you pregnant?	YES	NO
Are you taking any herbal preparations? (St. John's Wort)	YES	NO
Have you been on Accutane in the last 6 months?	YES	NO
Do you wear contact lenses?	YES	NO
Do you have dental fillings? Or metal pins?	YES	NO
History of skin cancer or atypical moles?	YES	NO
Any tattoos or permanent cosmetics?	YES	NO
Recent vaccinations?	YES	NO
Facial implants? If yes, explain	YES	NO Explain: ________________________

PLEASE ANSWER THE FOLLOWING TO THE BEST OF YOUR ABILITY

When exposed to the sun **without protection** for about 1 hour:

I. Always burns, never tans ____________

II. Always burns, sometimes tans ____________

II.I. Sometimes burns, sometimes tans ____________

IV.. Always tans ____________

V. Hispanic, Asian, Mediterranean, Middle Eastern, Native American ____________

VI. African American ____________

What is your ethnic ancestry? ____________________

When were you last exposed to the sun or tanning booth? ______________Do you use tanning lotions? YES NO

Have you ever had skin resurfacing or photo rejuvenation? YES NO

Reason for visit? ____

What are your goals for your skin? ____

Please see the next page.

Fitzpatrick Skin-Type

Print Name: ______________________________________ Date: ____________________________

Skin type is often categorized according to the Fitzpatrick skin type scale which ranges from very fair (skin type I) to very dark (skin type VI). The two main factors that influence skin type and the treatment program devised by your doctor are: Genetic disposition, and reaction to sun exposure and tanning habits.

By using the information, you provide on this form, we can be better prepared to provide you with the best care.

Please circle which applies to you

Pre-Existing Conditions

Please mark if you have a history of or are currently suffering from any of the following

Skin

_____ Athlete's Foot
_____ Sin/Toenail Fungus
_____ Hyperpigmentation
_____ Rashes
_____ Warts
_____ Boils/Abscesses
_____ Eczema
_____ Cuts/Open Wounds/Bruises
_____ Keloid Scarring

Digestive

_____ Constipation
_____ Bloating
_____ Diverticulitis
_____ IBS

Circulatory

_____ Cardiovascular Disease
_____ Hypotension
_____ Hypertension
_____ Ongoing Fever
_____ Varicose Veins/Clots/Phlebitis
_____ Lymph Edema
_____ Hemophilia
_____ Stroke
_____ Pacemaker
_____ Swelling/Stiffness

_____ Seizures
_____ Pinched Nerves
_____ Herpes/Shingles
_____ Numbness/Tingling
_____ Sciatica
_____ Multiple Sclerosis

Other

_____ Cancer/Tumors
_____ Diabetes
_____ Depression
_____ Drug/Alcohol Addiction
_____ Nicotine/Caffeine Addiction
_____ Breast Implants
_____ Facial Implants
_____ Acute Trauma
_____ Sleep Disorder
_____ Auto Immune Disorder
_____ Infectious Conditions
_____ Sinus Problems
_____ Asthma
_____ Thyroid Dysfunction
_____ Hepatitis A, B, C
_____ Cold Sores
_____ HIV
_____ Birth Control
_____ Other _______________
____

Emerge Medical & Well Spa

Dr. Ladd Atkins, D.O.

Missed Appointment / Cancellation Policy

We understand the need to move or cancel an appointment, however, to protect our therapists and be courteous to clients on our waiting list, we ask you cancel or reschedule within 24 hours or a $50 fee will occur. The same applies for appointments that are missed without notice**.** Please note if you arrive for your appointment 15 minutes beyond the scheduled start time, we are required to reschedule your appointment. Cancellation fees will apply.

Returned Check Policy

It is Emerge policy on returned checks to charge a fee of $45 plus the amount of the check. This fee must be paid in cash or with credit card within 7 days. If we do not receive the payment in our office within 7 business days, the check will be sent to Tulsa County District Attorney.

Refund Policy

Products may be returned within 2 weeks of purchase (restrictions may apply) along with the *original receipt* to receive a Emerge Account Credit. This credit will be applied to your account to use towards a future purchase. All sales are final on services.

HIPAA

I acknowledge that I have been offered information concerning the Health Insurance Portability and Accountability Act of 1996, or HIPAA.

General Policy

I understand that massage therapy and spa treatments are given for the purpose of stress reduction, skin purification, reduction of muscle tension and pain, and to increase circulation and energy flow. Estheticians, Cosmetologists, Physician Assistants, and Registered Nurses do not diagnose. I have stated all physical or mental condition, and nothing said during treatment should be construed as a diagnosis or treatment. I have stated all known conditions and take full responsibility to inform the medical and spa therapists of any new information regarding my physical condition.

The spa reserves the right to recommend that I reschedule a treatment or even refuse service at the therapist's discretion if you have certain conditions, including intoxication that are contraindicated for skin and body services. Emerge Medical & Well Spa reserves the right to change the price of services at any time. Emerge Medical & Well Spa employees have access to my client files for the purpose of assessing, recommending, and performing the most effective and proper services for myself.

Photo and Video Consent & Release

I, ____, do hereby agree to the following. I am allowing Emerge Medical & Well Spa or delegated photographer to take photos and videos of my treatment and/or treated areas to be used for the purpose of monitoring my progress. I give permission for my photos and or videos to be used for educational, advertising and social media purposes within the Emerge brand.

I attest the above statements to be true, my treatment provider and Emerge Medical & Well Spa staff relies on the information I provided for safe and effective treatment.

Print Name: ____ Date: _______________________________

Signature: ____ Date: _______________________________

Signature of Guardian, if applicable: ____________________ Date: _______________________________