HUGHES CENTER FOR AESTHETIC MEDICINE

1765 S. SPRINGDALE ROAD, SUITE B-2
CHERRY HILL, NJ 08003

GENERAL PATIENT INFORMATION and SKIN CARE QUESTIONANAIRE

Today's Date: ______________________________
Name: ____ Date of Birth: ___________ (Age) ______
Address: ____
City/State/Zip: ____
Cell Phone: ( ) ______________________ Home Phone: ( ) _________________________
Business Phone: ( ) _______________________ Please circle best # to contact you.
Email Address: ____
Occupation: ___________________________ Gender: Male/Female/Other Do you have children: Y N
Marital Status: M S D W Spouse's Occupation: __________________________________
Primary Care Physician (REQUIRED): _________________________ Phone: ( ) _______________
Pharmacy number: ______________________________
Have you seen a dermatologist: Y N
If yes, name and address: ____
Medications & Dosage: (include over the counter medication) NONE or please list:

____

____

Drug Allergies (Please list reaction):

____

Have you ever had Hepatitis B: Y N Hepatitis C: Y N HIV: Y N
Do you suntan?: Y N Do you use sunscreen?: Y N
Please name the brand of products you are currently using:
Cleanser: ______________________ Toner: ______________________ Scrub: __________________
Moisturizer: ________________________ Mask: ____________________ Other: _________________
Have you ever used Retin-A? Y N If yes, what strength? _____________
Have you ever used Hydroquinone? Y N
Have you ever been on Accutane? Y N If yes, when? __________
Have you ever been treated with Phenol or Trichloroacetic? Y N
Have you ever had herpes, hives, cold sores, fever blisters or keloids? Circle any that apply
If yes to any of the above, please state when and describe: ____________________________________
Do you smoke? Y N If yes, how many per day? _______________
In case of emergency (REQUIRED):
Name: ______________________________________ Relationship: ___________________________
Address & Telephone: ____
Do we have your permission to leave a message on your machine and/or with family members? Y N

PLEASE SIGN: ____

Aesthetic Needs Assessment

Please complete this questionnaire to help us better understand your aesthetic needs and concerns. During your consultation, your responses will help us identify personalized treatment options.

Name:	Date:

What is the main reason you are here for this consultation?		
What aesthetic treatments and procedures, if any, have you had in the past?		
If you have previously had any aesthetic treatments or procedures, were you pleased with the outcome? If no, in what way(s) were you dissatisfied?	❑ Yes	❑ No
Do you have any concerns about aesthetic treatments or procedures? If yes, please identify your concerns.	❑ Yes	❑No
Do you feel like you look older than you really are?	❑ Yes	❑ No
Do you have any concerns about wrinkles or fine lines?	❑ Yes	❑ No
Are you happy with the size, shape and volume of your lips?	❑ Yes	❑ No
Do you have any concerns about sun damage or age spots?	❑ Yes	❑ No
Do you have any concerns about the appearance of your skin?	❑ Yes	❑ No
Do you want to learn more about skin care products endorsed by our provider?	❑ Yes	❑ No

Aesthetic Products, Treatments, and Procedures

Please let us know which of the following aesthetic products, treatments, and procedures interest you. Please check all that apply.

❑ Wrinkle relaxer/Botulinum Toxin Type A	❑ Sunscreen Advice
❑ Dermal Filler/Wrinkle filler	❑ Topical Wrinkle Treatments
❑ Professional Skin Care Products	❑ Laser Treatments
❑ Lip Treatments	❑ Skin Rejuvenation
❑ Surgical Procedures	❑ Body Treatments:
❑ Laser Hair Removal	❑ Coolsculpt:
❑ Aesthetician Services	❑ Other:

Please tell us about your concern

With respect to facial aesthetics, please highlight those areas of the face that bother or concern you.
In the boxes provided, please rate these areas on a scale of 1-5.

1 = least concerned

5 = most concerned

Please feel free to draw on the chart to identify any other facial concerns you have.

Please score your areas of concern

	☺ 1	2	😐 3	4	☹ 5
Frown Lines	❑	❑	❑	❑	❑
Temples	❑	❑	❑	❑	❑
Under Eyes	❑	❑	❑	❑	❑
Laugh Lines	❑	❑	❑	❑	❑
Marionette Lines	❑	❑	❑	❑	❑
Jawline and Chin	❑	❑	❑	❑	❑
Forehead	❑	❑	❑	❑	❑
Brow	❑	❑	❑	❑	❑
Cheeks	❑	❑	❑	❑	❑
Lipstick Lines	❑	❑	❑	❑	❑
Corners of Mouth	❑	❑	❑	❑	❑
Lips	❑	❑	❑	❑	❑

Additional information or concerns you would like to discuss:

How did you hear about us?

❑ The internet	❑ Magazine	❑ Television
❑ Facebook	❑ The yellow pages	❑ Saw the provider at a seminar.
❑ Radio	❑ Friend or family member	❑ Other:
❑ Another healthcare provider (name):		

Approval to send information by text message, email or mail.	*Signature*

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Hughes Center for Aesthetic Medicine. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department

Other uses and disclosures require your authorization. Disclosure of your health information or its use for for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

Fund Raising. Unless you request us not to, we will use your name and address to support our fund raising efforts. If you do not want to participate in fund raising efforts, please check off the following box.

[ ] Please do not use my information for fund raising purposes.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

(Over)

Hughes Center for Aesthetic Medicine Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Jean Mulhall or Kristina Place, our Privacy Official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Hughes Center for Aesthetic Medicine
1765 South Springdale Road, Suite B-2
Cherry Hill, NJ 08003

Acknowledgement of Receipt of Notice of Privacy Practices

Hughes Center for Aesthetic Medicine reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for Hughes Center for Aesthetic Medicine

____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

the Hughes CENTER
1765 S Springdale Rd • Suite B2 • Cherry Hill, NJ 08003
www.DrNewYou.com • 856.751.4554

Patient Information Form

Please print all the information in the spaces provided. Be sure to complete and sign the statement on this form.

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I, _________________, hereby authorize SUSAN M. HUGHES, MD FACS to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, SUSAN M. HUGHES, MD FACS can refuse to treat me.

I have been informed that SUSAN M. HUGHES, MD FACS has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying SUSAN M. HUGHES, MD FACS in writing, but if I revoke my consent, such revocation will not affect any actions that SUSAN M. HUGHES, MD FACS took before receiving my revocation.

I understand that SUSAN M. HUGHES, MD FACS has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that SUSAN M. HUGHES, MD FACS restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that SUSAN M. HUGHES, MD FACS does not have to agree to such restrictions, but that once such restrictions are agreed to, SUSAN M. HUGHES, MD FACS must adhere to such restrictions.

____ ____________________

Signature of patient or patient's representative Date
(Form MUST be completed before signing.)

____

Printed name of patient or patient's representative

____

Relationship to the patient