CALIFORNIA FACE INSTITUTE

INTAKE FORMS
CONSULTATION

FULL NAME

DATE OF BIRTH | AGE | PHONE | EMAIL

ADDRESS | CITY | STATE | ZIP

CONFIDENTIAL INFORMATION

Todays Date

When would your like your surgery to be done?_____

MEDICAL HISTORY

Height: _____ Weight:_____

Do you take any prescription medication?
☐ Yes ☐ No

Please provide a list of your current medications, include supplements and vitamins.

1._____ 4._____
2._____ 5._____
3._____ 6._____

Have you had surgeries before? (Please List)

1._____ 4._____
2._____ 5._____
3._____ 6._____

Any important personal illness?

1._____ 4._____
2._____ 5._____
3._____ 6._____

Any important hereditary illness?

1._____ 4._____
2._____ 5._____
3._____ 6._____

You or your family had been suffered coagulation problems as thrombus or bruises? ☐ Yes ☐ No

Please check any health problems, past or present:

- ☐ Asthma
- ☐ Hepatitis
- ☐ Lupus, scleroderma
- ☐ Shortness of breath
- ☐ Blood clots
- ☐ Seizures
- ☐ Hormonal Problems
- ☐ High Blood Pressure
- ☐ Fainting
- ☐ Liver disease
- ☐ Diabetes
- ☐ Heart problems
- ☐ Keloid scars
- ☐ Weight loss
- ☐ HIV/ARC/AIDS
- ☐ Ankle swelling
- ☐ Cancer (Type: _____)
- ☐ Cystic Acne
- ☐ Cold sores/Herpes
- ☐ Stomach problems
- ☐ Thyroid
- ☐ Kidney disorder
- ☐ Psychiatric problems
- ☐ Migraines

☐ Other:_____

Name & Signature:_____
Date:_____/_____/_____

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MEDICAL HISTORY CONTINUED

Please answer yes or no to the following questions and list details:

YES NO

- ☐ ☐ Do you have any history of substance abuse?
- ☐ ☐ Do you have a personal or family history of Malignant Hyperthermia?
- ☐ ☐ Are you using any prescribed medications, (including topical medicines for acne or pigmentation)? List_____
- ☐ ☐ Are you using any Herbal medications? List_____
- ☐ ☐ Are you allergic to any medications, cosmetic ingredients, foods or latex? List _____
- ☐ ☐ Are you pregnant or trying to become pregnant?
- ☐ ☐ Do you use oral contraceptives?
- ☐ ☐ Do you use hormone replacement therapy?
- ☐ ☐ Do you smoke? How much? _____ How long? _____
- ☐ ☐ Have you had a mammogram? When? _____Where? _____Result? _____
- ☐ ☐ Do you Exercise? If yes, how often?_____
- ☐ ☐ Have you been hospitalized for any reason? If yes, please explain why?
- ☐ ☐ Do you agree with blood transfusion if needed?
- ☐ ☐ Do you drink alcoholic beverages? If yes, how many units per week?_____
- ☐ ☐ Do you smoke? If yes, how many per day ? _____
- ☐ ☐ Do you use recreational drugs?

What procedure(s) are you interested in?

What parts of your body are you interested in to discuss possible intervention?

I certify that the above information is correct to the best of my knowledge.
I declare that I have not hidden information about medical history, medical conditions or diseases suffered in me or in my family.

I was advised of the HIPAA Notice of Privacy Practices. Our HIPAA Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. You may request a copy of the Notice of Privacy.

Signature:_____ Date:_____
Print Name:_____

AUTHORIZATION
PHOTO / VIDEO RELEASE

FULL NAME

VIDEOTAPE & PHOTOGRAPH RELEASE

I hereby irrevocably consent to and authorize the use and reproduction by California Face Institute, APC and its affiliates, or anyone authorized by any of them, of any and all photographs, electronic images or video footage of me taken by any authorized individuals or that the practice has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including the website and social media sites such as YouTube, Facebook and Twitter. The Images (including any photographic negatives) shall be the sole property of California Face Institute, APC. The practice shall have the right to use my name in connection therewith if it so chooses.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge and agree to hold harmless California Face Institute, APC and its affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I hereby warrant that I am over eighteen years of age, and competent to contract in my own name insofar as the above is concerned.

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Signature:_____ Date:_____
Print Name:_____

I have read the above Release and Authorization. I am the parent, guardian, or conservatory of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization in the interest of public education.

Signature:_____ Date:_____
Print Name:_____

CALIFORNIA FACE INSTITUTE

COVID-19
LIABILITY WAIVER

FULL NAME

DATE

COVID-19 INFORMATION

As a matter of transparency, we are mandating that you sign a COVID-19 waiver. We are following all Federal (CDC), and State rules and regulations. In particular we are strictly following CO Executive Orders D 2020 044/45 and CDPHE PHO 20-28/29 regarding elective Medical Offices and Services. If you do not wish to sign this form, you will not be offered aesthetic services in our office at this time. Sars-CoV2 causing COVID-19 is a new and potentially threatening disease. If acquired, you may have no symptoms or develop life or limb/organ threatening complications, disability, job loss, family loss, and death. The purpose of this COVID-19 waiver is to allow you informed consent regarding your voluntary wishes to receive medical grade aesthetic services at our office. Such services are not risk free. In addition to usual aesthetic risks, you are now at risk for COVID-19, despite any and every best effort on our behalf to protect you in our spa. COVID-19 testing detection methods may miss COVID-19 disease. Due to your voluntary consent to receive such aesthetic services, even despite the CDC, DORA, CDPHE best intent, actions and our ability to follow those government orders, we cannot accurately predict whom would or would not acquire COVID-19, or whom transferred COVID-19 to whom.

Have you had a fever in the last 24 hours of 100°F or above?

Do you know, or have you recently, had any respiratory or flu symptoms, sore throat, or shortness of breath?

☐ Yes ☐ No

Have you been in contact with anyone in the last1 4days who has been diagnosed with COVID-19 or has coronavirus-type symptoms?

☐ Yes ☐ No

COVID-19 is a highly contagious virus that spreads from person to person. In addition to long-held and explicit sanitation measures, this business has always adhered to, new preventative measures have been put in place to further reduce the spread of this novel coronavirus. However, these best practices still offer no guarantee regarding your potential risk of being infected.

If you wish to proceed with your procedure, please print & sign your name below

Signature:_____ Date:_____
Print Name:_____

Guardian Signature (in case of a minor): _____Date:_____
Print Name:_____

Failure to sign this document is a dismissal from any services at our practice at this time. We thank you for reviewing our COVID-19 consents for your own health and benefit. We respect your health and decisions therein. Thank you.