REJUV CENTER FOR COSMETIC REJUVENATION

Richard E. Marki, M.D.
59 Mine Brook Road, Bernardsville, NJ
TEL. (908) 630-0007

Please provide the following information as accurately as possible.

Date:_____/_____/_____ Home Phone: (_____)_____-_____ Cell:(_____)_____-_____

Patient Name:_____ SS#_____/_____/_____

Street Address:_____City:_____State:____Zip:_____

Sex: M F Age:____ Birth Date:_____/_____/_____ Single Married Divorced Widowed

_____

Patient Employed by:_____ Occupation: _____

Employer's Address: _____ Phone:(_____)_____-_____

_____

Spouse (or responsible party) Name: _____

Birth Date:_____/_____/_____ SS#_____/_____/_____

Address (if different from above):_____

Phone: (_____)_____-_____ Cell: (_____)_____-_____

_____

Pharmacy: _____Phone: (_____)_____-_____

Referred by:

- ☐ Spa Rejuv: _____
- ☐ Advertisement: _____
- ☐ Other:_____

E-MAIL:_____

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Medical History

- **Reason for your visit?** **Please Specify Location Below**

❒ Sun Spots _____ ❒ Tone/Texture _____

❒ Wrinkles _____ ❒ Acne Scars _____

❒ Keratoses _____ ❒ Vein Issues _____

❒ Hair Removal _____ ❒ Other _____

▪ **Do you have a history of the following?**

❒ Diabetes ❒ Herpes Sores ❒ Contact Dermatitis ❒ Bleeding Disorders
❒ Rash ❒ Skin Injuries ❒ Easy Bruising ❒ Pacemaker/AICD
❒ Psoriasis ❒ Keloid Scarring ❒ Cold Sores ❒ Other _____

- **Are you Pregnant/ Nursing or planning a pregnancy soon?.....** ❒ Yes ❒ No
- **Are your skin problems caused by pregnancy? .....** ❒ Yes ❒ No
  If so are they getting worse? ..... ❒ Yes ❒ No
- **Have you ever been treated for this problem? ……..** ❒ Yes ❒ No
  If yes, when: _____
  By what method?_____
- **Are you using any of the following medications:**

❒ Aspirin ❒ Hormones ❒ Contraceptives ❒ Appetite Suppressants
❒ Sedatives ❒ Anti-Coagulants ❒ Tranquilizers ❒ Doxycycline (for acne)
❒ Accutane ❒ Topical Tretinoids ❒ Cortisone ❒ Topical Hydroquinones
❒ Other:_____

- **Are you currently or have you ever taken Accutane? ……..** ❒ Yes ❒ No

If yes, when did you last take it? _____

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- **Are you currently on any other skin treatment therapies? ……..**❒ Yes ❒ No

  If yes, please specify: _____

- **Have you had previous skin treatments? ……..**❒ Yes ❒ No

  Peels, Laser Treatments, Botox, Fillers, etc?

  If yes, please specify: _____

- **Are you using any bleaching agents or exfoliants?.....**❒ Yes ❒ No

  If yes, list: _____

- **Is your skin:** ❒ Normal ❒ Dry ❒ Oily

- **Do you have "sensitive skin"?.....**❒ Yes ❒ No

- **How much do you smoke daily?** _____

- **How much alcohol do you drink daily?** _____

- **Do you have any allergies?.....**❒ Yes ❒ No

  ❒ Medications ❒ Anesthesia ❒ Seasonal ❒ Skin related

  If yes, specify: _____

- **Do you wear contact lenses?.....**❒ Yes ❒ No

- **How long has it been since your last tanning experience/direct sun exposure**

  of greater then 45 minutes?_____

- **Do you use sun tanning lotions?.....**❒ Yes ❒ No

- **Are you planning a holiday or extended time in the sun?.....**❒ Yes ❒ No

  If yes, when: _____

- **Are you taking any herbal preparations? (i.e., St Johns Wort) ……..**❒ Yes ❒ No

  If yes, please list _____

Patient Skin Classification

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- **Fitzpatrick Skin Type _____ (based on exposure to summer sun)**

Type I	(very white or freckled) – Always Burn
Type II	(white) – Usually Burn
Type III	(white to olive) – Sometimes Burn
Type IV	(brown) – Rarely Burn
Type V	(dark brown) – Very rarely burn
Type VI	(black) – Never burn

- **Fitzpatrick Wrinkle Class _____ (degree of wrinkling)**

I	Fine wrinkles
II	Fine to moderate depth wrinkles, moderate number of lines
III	Moderate to deep wrinkles, many lines, with or without redundant skin folds

Patient's Signature _____ Date_____

Acknowledge of Privacy Policy

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The Undersigned consents to the use or disclosure of my (or patients if the Undersigned is the patients personal representative) individually identifiable health information by Rejuv - The Center for Cosmetic Rejuvenation, LLC, its physicians and staff. As outlined by Federal Law, for the purposes set fourth below:

1. To provide the patient with medical treatment and related services, including coordination or management of patients cares with a third party that is also involved in patient's treatment, such as your primary care physician, a specialist, or a laboratory to which we refer the patient for further care or tests.

2. As necessary to run our business operations and to support the core functions of treatment and payment, including without limitations, quality assessment and improvement activities, employee evaluation activities, conducting medical reviews, legal auditing services, business planning and development activities, and business management and general administrative activities.

3. As required or permitted by applicable state and /or federal law as described at greater length in the "Notice of Privacy Practices" provided to you along with this acknowledgement of privacy policy.

Furthermore, in order to facilitate and expedite my care, my signature below authorizes the office of Dr. Richard Marki and Dr. Richard Swift to have access to and obtain copies of my prior, current, and future medical records (physician, hospital, laboratory, etc) for the purpose of treatment and payment in accordance with the HIPPA regulation. In addition, my signature below confirms that I have received the complete "Notice of Privacy Practices." This authorization will remain valid until my written revocation.

_____ _____
Print Name of Patient (or Patients Representative) Date

_____ _____
Signature of Patient (or Patients Representative) (Relationship to Patient)

Consent To Use and Disclose Patient Health Information

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1. Patient received Notice of Privacy Practice. _____Initials

2. Patient agrees to have messages left on home answering machine, voicemail or cell-phone voicemail regarding appointments and lab results. _____Initials

3. Patient agrees to receive appointment reminders and lab results by mail to address listed in the medical record. _____Initials

4. Patient understands that they may list alternative methods or receiving health information ex. E-mail, other addresses of phone numbers.

   Please list: _____ _____Initials

   _____

5. Patient authorizes the release of his/her health information to the following family member(s) close personal friend(s), or other person(s).
   Please list: _____ _____Initials

I have read the above policies and agree to its terms.

_____ _____
Print Name of Patient (or Patients Representative) Date

_____ _____
Signature of Patient (or Patients Representative) (Relationship to Patient)

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI).* The individual is also provided the right to

request confidential communications or that a communication of *PHI* is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (Please check all that apply)

❒ **Home telephone**

- ❒ O.K. to leave a message with detailed information
- ❒ Leave a message with call back number only

❒ **Work telephone**

- ❒ O.K. to leave a message with detailed information
- ❒ Leave a message with call back number only

❒ **Cell phone**

- ❒ O.K. to leave a message with detailed information
- ❒ Leave a message with call back number only

❒ **Written Communication**

- ❒ O.K. to mail to my home address
- ❒ O.K. to mail my work/office address
- ❒ O.K. to fax to this number: _____

❒ **Other** _____

_____ _____
Print Name of Patient (or Patients Representative) Date

_____ _____
Signature of Patient (or Patients Representative) (Relationship to Patient)