Timeless Health MD

New Patient Form

Aesthetics . Basic

Name:_____Birthdate: _____ / _____ / _____

Mobile:_____ Email:_____

EMERGENCY CONTACT

In case of emergency I, _____ give consent to Dr. Tangchitnob and the office staff to relay any messages and information pertinent to my health to the following:

Name: _____ Phone: _____

Patient's Name Printed: _____

Patient's Signature: _____ Date: _____

GENERAL HEALTH HISTORY *Check if you have had or currently have any of the following:*

Current	Past		Current	Past		Current	Past	
☐	☐	Autoimmune Deficiency	☐	☐	Bleeding Disorder	☐	☐	Depression
☐	☐	Heart Attack	☐	☐	Anemia	☐	☐	Kidney Disease
☐	☐	Neurological Disease	☐	☐	Rheumatoid Fever	☐	☐	Gout / Hyperuricemia
☐	☐	Eating Disorder	☐	☐	Cancer	☐	☐	Diabetes
☐	☐	Heart Disease	☐	☐	Hypertension	☐	☐	Liver Disease
☐	☐	Pacemaker	☐	☐	Skin Allergies	☐	☐	Emphysema / COPD
☐	☐	Arthritis	☐	☐	Chemical Dependency	☐	☐	Lung Disease
☐	☐	High Cholesterol	☐	☐	Infection (Active)	☐	☐	Epilepsy / Seizures
☐	☐	Palpitations	☐	☐	Stroke	☐	☐	Migraine Headache
☐	☐	Asthma	☐	☐	Cold Sore / Fever Blisters	☐	☐	Gastric Reflux
☐	☐	HIV/AIDS	☐	☐	Keloid Scar Formation	☐	☐	Multiple Sclerosis
☐	☐	Psychiatric Care	☐	☐	Thyroid Disease			

SYMPTOMS *Please mark if you are experiencing any symptoms listed below:*

- ☐ Any current weight loss or poor appetite
- ☐ Diabetes
- ☐ Abnormal vision, headache
- ☐ Chest pain, heart palpitation
- ☐ Abnormal urination, leaking urination
- ☐ Abdominal pain, bloating
- ☐ Sleeping problems
- ☐ Hot-flashes
- ☐ Depression
- ☐ Abnormal bowel movement *(diarrhea, constipation, bloody stool)*
- ☐ Weakness
- ☐ Loss of sensation of extremities
- ☐ Backache
- ☐ Breathing difficulty

FAMILY HISTORY *Check if any of your blood relatives have had any of the following:*

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Obesity
- ☐ High Blood Pressure
- ☐ Other: _____

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How did you hear about us?:

■ Referral by Other	■ Instagram	■ Seminar / Event
■ Referral by Current Patient	■ Facebook	■ E-Newsletter
■ Internet Search	■ Television	■ Physician Office
■ Website	■ Local Salon / Spa	■ Other

Name of referring person (if applicable):_____ If other: _____

ALLERGIES *Including medications, food, cosmetics, latex, etc.:*

_____

_____

Other:

☐ Lidocaine ☐ Eggs / Chicken ☐ Collagen

☐ Beef ☐ Strawberries

CURRENT MEDICATIONS

_____

_____

HABIT

Alcohol ❒ Yes ❒ No Smoking ❒ Yes ❒ No. Recreational Drugs ❒ Yes ❒ No

If you answered yes, specify how much / how frequent (*e.g. alcohol intake per week, cigarette packs per day*)

_____

SURGICAL HISTORY *This includes c-sections, hysterectomies, appendectomies, etc.*

Procedure: _____ Date: _____ Procedure: _____ Date: _____

Procedure: _____ Date: _____ Procedure: _____ Date: _____

FOR WOMEN ONLY

Date of last menstrual period: _____

Are you pregnant? ❒ Yes ❒ No Are you trying to get pregnant? ❒ Yes ❒ No Are you nursing? ❒ Yes ❒ No

Are you currently on hormone replacement? ❒ Yes ❒ No Are you currently using contraception? ❒ Yes ❒ No

If yes, please provide names of medications:

_____

_____

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FINANCIAL POLICY

Please be advised that full payment for all services will be due at the time services are rendered. For your convenience we accept Visa, Master Card, Discover, Debit Card or Cash. We DO NOT accept personal checks.

NO SHOW OR CANCELLED APPOINTMENT POLICY

We do not accept clients without appointments. Appointments that are not cancelled 24 hours prior to the appointment time will be billed a $25.00 cancellation fee. Cancellation or no-show fees must be paid prior to making future appointments and are the sole responsibility of the client. Lipotropic injections missed cannot be credited for future injections. Repeated cancellations, or no-show appointments may result in termination from treatment at this practice.

CANCELLATION POLICY

If you purchase an aesthetic treatment package and do not complete the series, your bill will be reconciled at the individual treatment rate and any resulting credit can be applied only to a gift certificate or to additional services or products. If you withdraw from the Weight Loss Program, you will not be entitled to a refund of any previously paid monies.

My signature on this form confirms the authorization for Medical treatment by Dr. Tangchitnob and the staff at Timeless Health, MD.

Patient's Signature: _____ Date: _____

PHOTOGRAPHY CONSENT

I, _____ hereby authorize Dr. Edward/Dumrong Tangchitnob (or any member of their staff) to take before and after picture(s) of the treatment I am receiving. These photograph(s) may be used for my file, presentations, and/or promotional materials (including social media and websites) to show the results of my treatments.

Patient's Name Printed: _____

Patient's Signature: _____ Date: _____

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New Patient Form

Aesthetics . Consultation

WHAT PROCEDURES ARE YOU INTERESTED IN?

Check all that apply.

Treatment of Sun Damaged Skin

- ☐ Face
- ☐ Neck
- ☐ Chest
- ☐ Hands
- ☐ Arms / Forearms
- ☐ Legs

Removal of Fine Lines & Wrinkles

- ☐ Full Face
- ☐ Forehead
- ☐ Crow's Feet
- ☐ Lower Face
- ☐ Neck
- ☐ Between Eyes

Other Skin Care Services

- ☐ Chemical Peels
- ☐ Micro-Needling (Vampire Facial®)
- ☐ Skin Tightening
- ☐ Double Chin / Jowls
- ☐ Nitrogen Plasma Roller (RF Pixel)

Wellness Testing

- ☐ Hormone Testing & Evaluation
- ☐ Digestive Health
- ☐ Low Testosterone
- ☐ Detox & Cleanse Program
- ☐ Weight Loss Management (21 Day HCG Injections)

Body

- ☐ Liposuction
- ☐ Coolsculpting®
- ☐ Fat Destroying Ultrasound (Accent Prime)
- ☐ Lasor Liposuction with Fat Grafting (Beautifill™)

Injectable Fillers *(Juvéderm®/Restylane®/Versa/Bellafil®)*

- ☐ Lip Augmentation
- ☐ Smile Lines
- ☐ Marionette's Lines
- ☐ Smoker's Lines
- ☐ Volume Correction – Cheeks / Mid-face
- ☐ Lower Lids / Under Eyes

Pulsed Light Hair Removal

- ☐ Neck
- ☐ Back
- ☐ Chest
- ☐ Abdomen
- ☐ Underarms
- ☐ Forearms
- ☐ Upper Arms
- ☐ Beard (male)
- ☐ Bikini Line
- ☐ Full Leg
- ☐ Half Leg
- ☐ Upper Lip / Chin

Sexual Health

- ☐ Orgasm Shot
- ☐ Libido Pen
- ☐ Vaginal Tightening Laser
- ☐ Vaginoplasty
- ☐ Clitoral Hood Reduction
- ☐ Labiaplasty

Weight Gain / Low Sex Drive / Low Energy

- ☐ Hormone Imbalance
- ☐ PMS
- ☐ Pre-menopause
- ☐ Menopause
- ☐ Post-menopause
- ☐ Thyroid Disease

Medical Fitness

- ☐ Private Fitness Session
- ☐ Group Training Classes

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New Patient Form

Aesthetics . Extended

HISTORY OF PRIOR COSMETIC TREATMENTS

(e.g. laser acne treatments, chemical peels, etc.)

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

SKIN PHOTOTYPE TEST . FITZPATRICK CLASSIFICATION

for laser treatments

A. **Type I:** Always burns, never tans. Red or blond hair. Light eyes.

B. **Type II:** Burns easily, tans minimally. Blond hair. Light eyes.

C. **Type III:** Sometimes burns, tans gradually and uniformly. Brown hair. Blue/hazel eyes.

D. **Type IV:** Rarely burns, almost always tans well, also known as 'olive' complexion. Brown hair. Brown Eyes. Most light-skinned Blacks, Latinos and Asians.

E. **Type: V:** Rarely burns, tans profusely. Most medium Blacks, Latinos and Asians.

F. **Type VI:** Never burns, tans profusely and deeply. Most dark-skinned Blacks.

What is your natural hair color? _____

What is your eye color? _____

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Aesthetics . Extended

PATIENT CONSENT

Message and/or Appointment Reminders per HIPAA Regulations

Today's Date:_____

Name:_____Birthdate: _____ / _____ / _____

May we leave the following types of messages at your home, work, cell or personal email:

1. Office appointment reminders/changes ❒ Yes ❒ No
2. Labs and/or outpatient test results ❒ Yes ❒ No
3. Payment requirements for upcoming appointments ❒ Yes ❒ No
4. When authorization, medical records, or other information is needed ❒ Yes ❒ No
5. Prescription refill information ❒ Yes ❒ No
6. Receive office emails to my personal email account ❒ Yes ❒ No

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the privacy regulation, I hereby acknowledge that I have received a current copy of the privacy notice. You can find a copy of HIPPA form at our website www.tangchitnobmd.com under the office forms tab. I understand that is my responsibility to read through the given information, make any requests and provide documentation that may protect my confidentiality within this practice.

By way of signature, I provide Dr. Edward/Dumrong Tangchitnob with my authorization and consent to use and disclose my healthcare information for the purposes of treatment, payment and healthcare described in the privacy policies.

My healthcare information may be shared with the following persons:

Name & Relationship to Patient: _____

Name & Relationship to Patient: _____

No, my records may not be shared: _____

Patient's Signature: _____ Date: _____

Timeless
Health MD

Consent Form

for Neurotoxin (Botox, Dysport) Treatment

I _____ authorize **Dr. Tangchitnob** and/or associate physicians, to perform a cosmetic treatment upon me by injecting Botox Cosmetic beneath the skin of my face and/or neck.

I understand that Botox is produced by the Allergan Company and has recently been approved by the FDA for cosmetic use in the glabella area (above the nose and between the eyebrows) of the face.

I understand that Botox has been used for many years to treat a variety of different medical conditions including facial and cervical dystonia, muscle twitches, and facial wrinkles.

I understand that this is an elective procedure and the indication is my request for the smoothing of facial and/or neck dynamic wrinkles and the improvement of my appearance.

I understand that follow up treatments may be required for optimal results and that insurance will not cover the cost of the procedure.

I have been told that minor side effects are common and include temporary bruising and pain, which may last for a few days, Other potential risks include under-correction or over -correction of the problem being treated, facial asymmetry or muscle weakness, a flu-like syndrome, or the development of antibodies to Botox, Serious or long-lasting side effects are rare.

I understand that the results of Botox treatment are temporary and will wear off within four or six months and that my appearance will return to what it was before treatment was started.

I consent to photographs being taken before and during the course of my treatment to evaluate the effectiveness of this treatment.

Pre-treatment and post-treatment instructions have been given to me and the potential advantages and disadvantages of the treatment have been discussed with me. I have had the opportunity to look over the brochure on Botox treatment published by the Allergan Company. I have had all my questions answered and I freely consent to the proposed treatment.

I understand that if I gain excessive weight since previous assessments and the day of surgery, the physician reserves the right to change the areas to be treated if the planned areas would result in too much surgery.

Patient's Name Printed: _____

Patient's Signature: _____ Date: _____