



The Aesthetic and Wellness Center, PLC
3825 State Road 64 E Suite 300 Bradenton, FL 34208 941-749-0741

PATIENT INFORMATION FORM

Name: (Last) _____ (First) _____ (M.I.) _____ Sex: (M / F)
 SSN: _____ Birth Date: _____ Age: _____
 Home Address: _____
 City _____ State _____ Zip Code _____
 Home Phone: () _____ Cell Phone: () _____
 Email Address: _____
 Best number to reach you: _____

Alternative address: _____

Employment Information:

Employer: _____ Occupation: _____
 Phone: () _____ ext: _____

In Case of Emergency:

Name: _____ Relationship _____ Phone :() _____

How did you hear about us?

- | | | |
|--|---|--|
| <input type="checkbox"/> Magazine | <input type="checkbox"/> Physician office | <input type="checkbox"/> CitiRevealed |
| <input type="checkbox"/> Referral by Current Patient | <input type="checkbox"/> Sign/Location | <input type="checkbox"/> Seminar |
| <input type="checkbox"/> Coupon Book | <input type="checkbox"/> Gyms | <input type="checkbox"/> Television |
| <input type="checkbox"/> Radio advertising | <input type="checkbox"/> Television | <input type="checkbox"/> Newsletter |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> Website | <input type="checkbox"/> Local Spa/Salon |

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 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. Missed appointments cannot be credited to next week's treatment period. Lipotropic injections missed cannot be credited for future injections. If you are enrolled in a special program through your employer, cancelled or no show appointments will be applied to your treatment plan and will be charged to your treatment program. Repeat cancelled, or no-show appointments may result in termination from treatment at this practice.

Cancellation Policy

If you purchase a 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. In regards to the Weight Loss Program, if you withdraw from the program, you will not be entitled to a refund of any previously paid monies.

My signature on this form confers the authorization for Medical treatment by Inda Mowett, MD and her staff at The Aesthetic & Wellness Center.

Signature _____ **Date** _____



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MEDICAL HISTORY

Name: _____ Age: _____ Birth date: _____
 Today's Date: _____ Last Physical/Bloodwork: _____
 Primary Physician's Name: _____
 Office phone # (Primary Care Physician): _____

What is your reason for your visit today?

___ Cosmetic Services ___ Weight Management ___ Mesotherapy

General Health History

- | | | |
|-------------------------------|---------------------------|---------------------------------|
| ___ Autoimmune Deficiency | ___ Heart Attack | ___ Neurological Disease |
| ___ Eating Disorder | ___ Heart Disease | ___ Pacemaker |
| ___ Arthritis | ___ High Cholesterol | ___ Palpitations |
| ___ Asthma | ___ HIV/AIDS | ___ Psychiatric Care |
| ___ Bleeding Disorder | ___ Anemia | ___ Rheumatoid Fever |
| ___ Cancer | ___ Hypertension | ___ Skin Allergies |
| ___ Chemical Dependency | ___ Infection (active) | ___ Stroke |
| ___ Cold Sores/Fever Blisters | ___ Keloid Scar Formation | ___ Thyroid Disease |
| ___ Depression | ___ Kidney Disease | ___ Gout/Hyperuricemia |
| ___ Diabetes | ___ Liver Disease | ___ Surgery (Please list below) |
| ___ Emphysema/COPD | ___ Lung Disease | _____ |
| ___ Epilepsy/Seizures | ___ Migraine Headaches | _____ |
| ___ Gastric Reflux | ___ Multiple Sclerosis | _____ |

Allergies

- * Medications: _____
 * Food: _____
 * Cosmetics: _____
 * Latex/Other: _____
 * Are you allergic to: ___ Lidocaine ___ Beef ___ Strawberries ___ Eggs/ Chicken ___ Collagen

Current medications

Social History

___ Single ___ Married ___ Widowed
 Occupation: _____
 Do you smoke cigarettes? _____
 If yes, how many packs a day: _____
 Do you drink alcohol: _____
 If yes, weekly alcohol intake: _____



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Women only:

Date of last menstrual period: _____ Are you currently using contraception? _____
Are you pregnant? _____ Are you currently on hormonal replacement? _____
Are trying to get pregnant? _____ If yes, please provide name of medications: _____
Are you nursing? _____

Family History: Check if any of your blood relatives have had any of the following:

___ None ___ Cancer ___ Diabetes ___ Heart Disease ___ Stroke ___ Kidney Disease
___ Obesity ___ High Blood Pressure Other: _____

History of previous cosmetic treatments or procedures:

___ Ablative Laser ___ Laser Acne Treatments
___ Botox ___ Laser/IPL Hair Removal
___ Cellulite Reduction ___ Mesotherapy
___ Chemical Peels ___ Microdermabrasion
___ Dermal Fillers ___ Permanent Make-Up
___ IPL Fotofacial ___ Sclerotherapy
___ Medical Pedicure ___ Body sculpting
___ Skin Tightening

When did you have it done? _____

Are you currently taking/using?

___ Retin-A ___ Renova ___ Steroids ___ Prescription acne medication
Have you been taking Accutane for the past 12 months? _____

What line of skin products are you using? _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Print Name, Parent or Legal guardian

Date

Signature

Reviewed by/ Date



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Patient Consent: Message and/or Appointment Reminders
Per HIPAA Regulations

Today's Date _____

Patient Name: _____ DOB _____

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

- | | | |
|---|-----|----|
| 1. Office appointment confirmation/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, other info needed | Yes | No |
| 5. Prescription refill information | 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. I understand that it 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 Inda Mowett, MD 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.

Signature & Date

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 _____



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SKIN PHOTOTYPE TEST
FITZPATRICK CLASSIFICATION

Name: _____ **Date:** _____

Please circle the one that describes your skin type:

- A. Type I:** Always burns, never tans. Red or blonde 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-skinned Blacks,
Latinos, and Asians.
- F. Type VI:** Never burns; tans profusely, deeply. Most dark-skinned
Blacks.

What is your natural hair color? _____.

Eye color? _____.

Signature _____ **Date** _____



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**Informed consent for
(Photography & Media Release)**

I, _____ hereby authorize Dr. Inda Mowett or any member of her staff to take before and after picture(s) of the skin treatment, procedure or weight loss program I am receiving. These photograph(s) will be used to compare the results of the treatments you have received from us. I give authorization to have only portions of my face or body to be placed in photo albums or slide presentations to show the results of my treatments. I also give authorization to show my pictures under seal of anonymity, if Dr. Mowett requires using my pictures for future presentations, brochures, corporate websites, press kits, and/or other forms of advertisement.

Print Name

Sign Name

Date

If the above person is a minor (Under the age of 18), the signature of a parent or guardian is required below;

Print name of Parent or Guardian

Signature of Parent or Guardian

Date



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What procedures are you interested in?

Check all that apply

Treatment sun damaged skin (brown spots)

- Face
- Neck
- Chest
- Hands
- Arms/forearms
- Legs

Dermal Fillers

- Lip augmentation
- Smile lines
- Marionette's lines
- Smoker's lines
- Cheek augmentation
- Lower lids/sunken eyes

Removal of fine lines and wrinkles

- Full face
- Forehead
- Crow's feet
- Lower face
- Neck
- Face and neck

Pulsed Light Hair Removal

- Beard
- Neck
- Back
- Chest
- Abdomen
- Underarms
- Forearms
- Upper arms
- Beard (male)
- Bikini Line
- Full leg
- Half Leg

Facial veins & broken capillaries

- Full face
- Mid-face
- Nose/Cheeks
- Lower face

Laser acne treatment

- Full face
- Neck
- Upper back
- Complete back
- Chest

Treatment of Rosacea

- Full face
- Mid-face
- Nose/Cheeks
- Lower face

Mesotherapy/Body Sculpting

- Love handles
- Saddle Bags
- Baggy eyes
- Inner thighs
- Mid/Lower abdomen
- Inner thighs

Botox

- Frown lines
- Crow's feet
- Forehead
- Bunny Lines
- Neck bands

Pre-Wedding/Special Event Package

Weight Loss Programs

Skin Care Services

- Microdermabrasion
- Chemical Peels
- Skin Tightening
- Hand Rejuvenation