

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name _____ Today's Date _____

Date of Birth _____ Age _____ Occupation _____

Home Address _____ City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

Which of the following best describes your skin type? (Please circle one type number)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Brown, moderately pigmented skin
- VI Black skin

E-MAIL

Do you regularly use tanning salons or sun bathe? _____ How often? _____

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, for what: _____

Are you currently under the care of a dermatologist? ☐ Yes ☐ No

If yes, for what: _____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? ☐ Yes ☐ No

Do you have any of the following medical conditions? (Please check all that apply)

- ☐ Cancer ☐ Diabetes ☐ High blood pressure ☐ Herpes ☐ Arthritis
- ☐ Frequent cold sores ☐ HIV/AIDS ☐ Keloid scarring ☐ Skin disease/Skin lesions
- ☐ Seizure disorder ☐ Hepatitis ☐ Hormone imbalance ☐ Thyroid imbalance
- ☐ Blood clotting abnormalities ☐ Any active infection

Do you have any other health problems or medical conditions? Please list: _____

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) ☐Food ☐Latex ☐Aspirin ☐Lidocaine ☐Hydrocortisone ☐Hydroquinone or skin bleaching agents ☐Others: _____

MEDICATIONS

What oral medications are you presently taking? ☐Birth control pills ☐Hormones

☐Others (Please list): _____

Are you on any mood altering or anti-depression medication? _____

Have you ever used Accutane? ☐Yes ☐No, If yes, when did you last use it? _____

What topical medications or creams are you currently using? ☐Retin-A® ☐Others (Please list): _____

What herbal supplements do you use regularly? _____

HISTORY

Have you ever had laser hair removal? ☐Yes ☐No

Have you used any of the following hair removal methods in the past six weeks?

☐Shaving ☐Waxing ☐Electrolysis ☐Plucking ☐Tweezing ☐Stringing ☐Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? ☐Yes ☐No

Have you recently used any self-tanning lotions or treatments? ☐Yes ☐No

Do you form thick or raised scars from cuts or burns? ☐Yes ☐No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ☐Yes ☐No If yes, please describe: _____

For our female clients:

Are you pregnant or trying to become pregnant? ☐Yes ☐No Are you breastfeeding? ☐Yes ☐No

Are you using contraception? ☐Yes ☐No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date: _____

LISA S. BUNIN, M.D.
1611 POND ROAD, SUITE 403
ALLENTOWN, PA 18104
PH: 610-435-5333 – FAX: 610-435-2253

This information is completely confidential but will help us to serve you better.

What are your primary areas of concern? _____

Would you be interested in any of the following cosmetic services?

<input type="checkbox"/> Restylane	<input type="checkbox"/> Chemical Peels	<input type="checkbox"/> Sunscreen Advice
<input type="checkbox"/> AHA and Glycolic Peels	<input type="checkbox"/> Laser Resurfacing	<input type="checkbox"/> Removing Leg Veins
<input type="checkbox"/> Collagen Therapy	<input type="checkbox"/> Laser Treatment .s	<input type="checkbox"/> Facial and Hair Treatments
<input type="checkbox"/> Skin Rejuvenation	<input type="checkbox"/> Avage (tazarotene)	<input type="checkbox"/> Hair Removal
<input type="checkbox"/> Retin-A or Renova	<input type="checkbox"/> Skin Care Advice	<input type="checkbox"/> Spider Vein Treatments
<input type="checkbox"/> Microdermabrasion	<input type="checkbox"/> Skin Care Products	<input type="checkbox"/> Removing Facial Veins
<input type="checkbox"/> Botox Cosmetic	<input type="checkbox"/> Birthmarks	<input type="checkbox"/> Liver or Age Spot Treatments
<input type="checkbox"/> Acne Treatment	<input type="checkbox"/> Other, please specify _____	

Have you ever had fillers? (☐ Restalyne, ☐ Radiesse, ☐ Juvederm, ☐ Other _____)

Have you ever had Botox? ☐ yes ☐ no

Have you ever had Lasers? ☐ yes ☐ no if yes for what? _____

Have you ever had cosmetic surgery? ☐ yes ☐ no if yes for what? _____

Were you pleased with the outcome? ☐ yes ☐ no if not, Why? _____

If our office held a seminar for patients to learn more about certain cosmetic procedures, would you be interested in attending? _____

Skin Typing Worksheet

PATIENT NAME: _____ DATE: _____

Please answer the following questions by circling the number which best describes you. Your clinician will total the score during the consultation.

My ethnic origin is closest to:
(Circle one)

- I. Very fair (Celtic and Scandinavian).....
- II. Fair-skinned Caucasians with light hair and light eyes.....
- III. Pale-skinned Caucasians with dark hair and dark eyes.....
- IV. Olive-skinned (Mediterranean, some Asian, some Hispanic).....
- V. Dark-skinned (Middle Eastern, Hispanic, Asians, some Africans)
- VI. Very dark-skinned (African).....

My eye color is:

- Light Blue.....0
- Blue/Green.....1
- Green/Gray/Golden.....2
- Hazel/Light Brown.....3
- Brown.....4

My natural hair color at
Age 18 was:

- Red.....0
- Blonde.....1
- Light Brown.....2
- Dark Brown.....3
- Black.....4

The color of my skin that is
not normally exposed to
the sun is:

- Pink to Reddish.....0
- Very Pale.....1
- Pale with a Beige tint.....2
- Light Brown.....3
- Medium to Dark Brown.....4
- Dark Brown/Black.....6

If I go out into the sun for
an hour or so without
sunscreen and have not been
out in the sun for weeks,
my skin will:

- Burn, blister and peel.....0
- Burn, when the burn resolves there is little or no change.....1
- Burn, but turns to tan in a few days.....2
- Get pink, but turns to tan quickly.....3
- Just tan.....4
- Just gets darker.....5
- My skin color is so dark I can't tell.....6

When was the last time the
area to be treated was
exposed to natural sunlight,
tanning booths or artificial
tanning cream?

- Longer than one month ago.....0
- Within the past month.....1
- Within the past two weeks.....3
- Within the past weeks.....4

TOTAL SCORE

If your score is:	Your skin type is:	Notes:
0-3	Skin Type I	
4-7	Skin Type II	
8-11	Skin Type III	
12-15	Skin Type IV	
16-19	Skin Type V	
20-24	Skin Type VI	

LISA S. BUNIN'S PRIVACY NOTICE

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED (SHARED) AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Lisa S. Bunin and staff are legally required to Follow the policies in this notice. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). PHI includes information that can be used to identify you. We collect or receive this information about your past, present or future health or condition, to provide health care to you, or to receive payment for this health care. We must provide you with this notice that explains how, when and why we use and share your PHI.

WE MAY USE AND SHARE YOUR PROTECTED HEALTH INFORMATION for many different reasons. Below we describe the different categories of when we use and share your PHI. We give you some examples of each category. All of the ways we are permitted to use and share this information will fall within one of the categories.

- **For Treatment.** We may share your PHI with physicians, nurses, nursing home personnel, pharmacists and other health care personnel and agencies that provide or are involved in your health care. If you are being treated for an injury, we may share your PHI with a physician in order to coordinate your care.
- **To Obtain Payment for Treatment.** We may use and share your PHI in order to bill and collect payment for the services provided, to determine insurance eligibility or to obtain pre-authorization prior to treatment. It is important that you provide us with correct and up-to-date PHI. We may share portions of your PHI with our billing department and your health plan to get paid for the health care services we provided to you.
- **To Run our Health Care Business.** We may share your PHI in order to operate our medical practice according to healthcare regulations. They may include cost-management reviews, quality of care audits, compliance reviews and other administrative functions.
- **To Business Associates.** There are some services such as collection agencies that we contract with as business associate. We may share your information with them. However, we require our business associates to protect your PHI through contracted agreement.
- **When Government or Law Enforcement Agencies Request Your PHI.** We share your PHI

that we report information about victims of abuse, domestic violence or in response to a court order, subpoena, warrant, summons or similar request.

- **For Public Health Activities.** We report information about deaths, and various diseases to government officials and agencies such as the CDC and FDA. We will use or disclose your health information in order to prevent a serious threat to your health or safety, or the health or safety of the public or another person.
 - **For Health Oversight Activities.** We share your PHI with health oversight agencies as authorized by the law. Activities such as audits, investigations, inspections and licensure are necessary for the government to monitor the health care system, government benefit programs and our compliance with your civil rights.
 - **For Military and Veterans.** We may share your information as required by military command authorities. We may also share PHI about foreign military personnel with the appropriate foreign military authority.
 - **For National and Intelligence Activities.** We may share your PHI with authorized federal officials for lawful intelligence, counterintelligence and other national security activities authorized by law.
 - **For Protective Services for the President and Others. We may share your PHI with authorized federal officials so they may provide protections to the President, other authorized persons or foreign heads of state or for the conduct of special investigations.**
 - **For Worker's Compensation Purposes.** When we share your PHI to comply with worker's compensation laws or similar programs
 - **For Appointment Reminders and Health - Related Benefits Services.** We may use your name, address, e-mail and phone number to contact you to cancel or reschedule an appointment
 - **For Health Related Benefits and Services .**We may use or disclose your health information in order to inform you about health related benefits or services that may be of interest to you.
- A. You have the Opportunity to Object to Information Shared with Family, Friends or Others.** Unless you object , we may share your PHI to a family member, friend or other person that you choose in writing to involve in your care. Your choice to object may be made any time.
- B. Your Prior Written Consent is Required in Other Situations.** In situations not described above, we will ask for your specific written consent before using or sharing any of your PHI. If you choose to sign a specific consent to share your PHI, you can later cancel that consent in writing. This will stop any future sharing of your PHI

YOUR RIGHTS REGARDING YOUR PHI

- A. You Have the Right to Request Limits on How we Use and Share Your PHI.** If we accept your request, we will put your limits in writing and follow them except in emergency situations. You may not limit PHI that we are legally required or allowed to share.
- B. You Have the Right to Choose How We Communicate PHI to You.** All of our communication to you are considered confidential. You have the right to ask and we will send information to you at another address (for example work instead of home). You will be billed for any additional cost.
- C. You Have the Right to See and Get Copies of Your PHI.** But you must make this request in Writing. We will respond to you within 30 days after receiving your written request. If you request copies of your PHI, we will quote and charge you the current rate for each page.
- D. You Have the Right to Get a List of When and To Whom We Have Shared Your PHI.** This list will not include uses to which you have already consented. We will respond within 60 days of receiving your request. This list will include the last six years of activity. You may request a shorter time. The list will include dates when your PHI was shared and why, to whom your PHI was shared (including their address if known), and description of the information shared. The first list you request within a 12 month period will be free. You will be charged our cost for additional lists.
- E. You Have the Right to Correct, Update or Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct it. We can do this for as long as the information is kept by our facility. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. If we deny your request, our written denial will tell our reasons and explain how to tell us why you disagree. You have the right to request that the above information be attached to all future uses or sharing of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change.
- F. You Have the Right to Get a Copy of This Privacy Notice.**
- G. Please forward all request for information in writing to:** Office Manager
Lisa S. Bunin, M.D.
1611 Pond Road
Allentown, PA 18104

CHANGES TO THIS NOTICE

We may change the terms of this notice and our Privacy policies at any time. Any changes to this Notice will apply to the PHI that we already have.

Before we make any change to our policies, we will promptly change this notice and post a new notice in our waiting room. You may request a copy of this notice from the office manager at any time.

HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES. If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may send a written complaint to the person listed at the end of this notice. You may also send a written complaint to the Secretary of the Department of Health and Human Services.

You will not be penalized for filing a complaint.

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES:

HIPAA PRIVACY OFFICER
C/O Lisa S. Bunin, M.D.
161 Pond Road, Suite 403
Allentown, PA 18104

PRINT PATIENT NAME

SIGNATURE OF PATIENT

DATE

SIGNATURE OF AUTHORIZED REPRESENTATIVE

SIGNATURE OF AUTHORIZED REPRESENTATIVE

RELATIONSHIP