

Lohner Plastic Surgery

New Patient Info (Skincare)

Name _____

Address _____

City/State/Zip _____

Date of Birth _____ Female _____ Male _____

Home Phone () _____ Cell () _____

Email _____

Preferred method of contact (check one): Cell _____ Email _____ Home _____

Emergency Contact Name: _____ Phone: _____

How did you hear about Lohner Plastic Surgery? _____

General Health (circle one): Excellent Good Fair Poor

Do you have a Dermatologist? Y N If yes, who? _____

Pharmacy Name _____ Pharmacy Phone # () _____

Allergies (Food, Seasonal, +/-or Drug) Please List Below

Lohner Plastic Surgery

Skincare Health Intake

1. What is the reason for your visit today?

2. What special areas of concern do you have?

- Fine lines & wrinkles
- Uneven skin tone
- Pigmentation
- Sun damage
- Rosacea +/- or broken capillaries
- Acne +/- or pore congestion Describe: _____
- Excessive oil production
- Dry/Flaky
- Dehydrated
- Other _____

3. What medications do you use (including vitamins +/- or supplements)? _____

4. Do you wear contact lenses? Yes ___ No ___

5. Do you get cold sores or have a history of shingles?
Yes, explain _____ No _____

6. Do you: Sunbathe ___ Self-Tan ___ Use a tanning bed ___
If yes, how recent? _____

7. Have you ever had cosmetic +/- or reconstructive surgery?
If yes, please list +/- or explain _____

8. Have you ever had an allergic reaction to any of the following:

- LATEX
- Prescription Medication

- Seasonal/Environmental (ie pollen, grasses, trees, etc.)

- ANY FOODS (ie shellfish, peanuts, etc.)

- ANY cosmetics, skincare products, +/- or fragrances

- OTHER _____

9. Do you bruise easily? Yes ___ No ___

10. Have you had any of the following past or present:
 Skin Cancer (basal, squamous, or melanoma)? Y ___ N ___
If yes, explain _____

Any other type of cancer?
Yes, explain _____ N ___

Eczema ___ Psoriasis ___ Vitiligo ___ Other _____

Thyroid concerns?
Yes, explain _____ N ___

Lupus Y ___ N ___

HIV Y ___ N ___

Any other auto-immune concerns?
Yes, explain _____ N ___

Migraines Y ___ N ___

Diarrhea/Constipation Y ___ N ___

Pace maker or metal implants Y ___ N ___

11. For Women:

- Are you pregnant? Yes No
- Are you breastfeeding? Yes No
- Do you have menopause concerns? Yes No
- Do you take/use hormone replacements? Yes No

For Men:

- Do you get ingrown hairs on the face? Yes No
- What is your shaving preference? Razor ___ Electric ___

Skin

12. How would you rate your skin (choose one)?

- Always burns, never tans
- Burns easily, tans slightly
- Burns moderately, tans gradually
- Seldom burns, always tans easily
- Rarely burns, deep tan
- Never burns, deeply pigmented

13. Ethnic background(s) _____

14. Eye Color: Blue Green Hazel Gray Lt Brown Dk Brown

15. Natural Hair Color: Blonde Red Lt brown Med brown
Dk brown Black Gray/Silver White

16. How would you describe your skin?
Normal ___ Oily ___ Dry ___ Combination ___
Other _____

17. Have you ever taken Accutane? Yes ___ No ___

18. Have you ever used a topical antibiotic? Yes ___ No ___

19. Have you ever used Retin A? Yes ___ No ___

20. Have you ever used hydroquinone? Yes ___ No ___

21. Have you ever had (choose all that apply):
- Microdermabrasion
 - Chemical peels
 - Dermaplaning
 - Laser +/- or IPL _____
 - Botox or Dysport
 - Cosmetic fillers _____
 - ANY hair removing techniques _____

PATIENT PHOTO RELEASE CONSENT FORM

NAME _____

ADDRESS _____

I consent to the taking of photographs by Dr. Lohner or his designee of me or parts of my body in connection with the Plastic Surgery procedure(s) to be performed by Dr. Lohner.

I provide this authorization as a voluntary contribution in the interests of Public Education. I understand that such photographs can be used in any print, visual or electronic media, specifically including but not limited to, medical journals and textbooks, advertisements for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive from Dr. Lohner.

I understand that I have the right to inspect and copy the information I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it will not have any effect on any actions taken prior to my revocation. If I do revoke this authorization, it will expire ten years from the date written below.

I release and discharge Dr. Lohner, and all parties action under their license and authority from all rights that I may have in photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

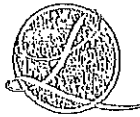
Signature

Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____, a minor. I am authorized to sign this authorization on his/her behalf, and I give this authorization as a voluntary contribution in the interest in Public Education.

Signature

Date



LOHNER
 PLASTIC SURGERY
 919 Conestoga Road, Bldg 1, Ste 200
 Bryn Mawr, PA 19010

Patient Record of Disclosures

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provides the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individuals home.

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

Telephone _____

O.K. to leave detailed message

Leave message with call back number only

Work Telephone _____

O.K. to leave detailed message

Leave message with call back number only

Written Communication

O.K. to mail to my home address

Other _____

I authorize the practice to disclose my PHI to those individuals listed below:

Name	Relation	Contact Number

The information that can be disclosed to the above individuals includes:

All PHI

Only information relating to appointments and payments

Other: _____

With the option to exclude:

None

HIV/STD information

Any health diseases

Other: _____

 Patient Signature

 Date

LOHNER PLASTIC SURGERY
Ronald A. Lohner, M.D.

Privacy Practices Acknowledgement

Acknowledgement Form:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Today's Date _____

Annual acknowledgement:

Sign _____ Date _____

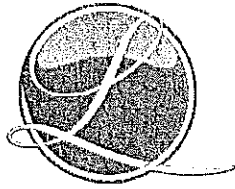
Sign _____ Date _____

Sign _____ Date _____

Sign _____ Date _____

Sign _____ Date _____

Sign _____ Date _____



LOHNER

PLASTIC SURGERY

919 Conestoga Road, Bldg 1, Ste 200
Bryn Mawr, PA 19010

Medspa Cancellation & No Show Policy

At Lohner Plastic Surgery, our goal is to provide each patient with the highest level of care and attention. We understand it is sometimes necessary to change or cancel your appointment. We will always do our best to accommodate those schedule changes.

- We ask all patients to provide **24 hours' notice** to change or cancel your appointment. Cancellations/Reschedules made after that time **or no shows** are subject to a \$150 cancellation fee.
- This fee will be collected upon booking all appointments and applied to service on the day of your treatment.
- Appointments are permitted a 10 minute grace period for delays. We will always try our best to accommodate late arrivals but it may be necessary to reschedule or shorten your appointment.
- Booking for Sculptra requires a 50% non-refundable deposit. Appointments may be rescheduled up to 7 days prior to the date of the appointment. Cancellations/Reschedules made after that time will result in a loss of the deposit.

Patient Name (print) _____

Signature _____ Date _____

Office Use:

Taken by _____

- CC updated