



949-650-SCMS [www.southcoastmedspa.com](http://www.southcoastmedspa.com)

### Medical History

In order to provide you with the most appropriate skin care treatment, we would appreciate your time in completing 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 skin 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

#### MEDICAL HISTORY

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

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

Do you have a history of livido reticularis, an autoimmune disease, in which the blood vessels are constricted, or narrowed resulting in mottled discoloration on large areas of the leg or arms? Yes

Do you have a history of erythema ab igne, which is a persistent skin rash produced by prolonged or repeated exposure moderately intense heat or infrared irradiation? Yes

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: \_\_\_\_\_

What Oral modifications are you presently taking?  ACCUTANE  birth control pill  
 hormones  others (please list): \_\_\_\_\_

Have you ever used Accutane?  Yes  No. If yes, when did you last use it? \_\_\_\_\_

What topical modifications or creams are you currently using?  RetinaA  
 Others (please list) \_\_\_\_\_

Have you ever had laser hair removal?  Yes  No

Have you ever 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 using contraception?  Yes  No

Are you breastfeeding?  Yes  No

Allergies

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  cosmetics  aspirin  lidocaine  hydrocortisone  hydroquinone or skin bleaching agents  sulfa medications  others

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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, physician assistant, physician, or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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**Client Sign in Sheet**

First Name: \_\_\_\_\_ Date: \_\_\_\_\_

Last Name: \_\_\_\_\_

E-mail: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Home phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ zip: \_\_\_\_\_

Birthday: \_\_\_\_\_

*How were you referred to us?*

- Friend (please tell us who) \_\_\_\_\_
- Internet (which search engine) \_\_\_\_\_
- Magazine/Publication (which one) \_\_\_\_\_
- Drive by \_\_\_\_\_
- Other (please explain) \_\_\_\_\_

What is the #1 reason for choosing South Coast MedSpa? \_\_\_\_\_

*Please indicate what procedure you are having performed today.*

- Laser Hair Removal (Permanent Reduction of Unwanted Hair)
- Active FX (Tighten, Tone, and Texture...“Face Lift with a Laser?”)
- Skin Care

*What procedures are you most interested in for your next visit?*

- Laser Hair Removal
- Active FX
- Skin Care

## **FITZPATRICK SKIN TYPE CLASSIFICATION**

### **GENETIC DISPOSITION**

Score	0	1	2	3	4
What are the color of your eyes?	Light blue, Gray, or Green	Blue, Gray, or Green	Blue	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blond	Chestnut/Dark Blond	Dark Brown	Black
What is the color of your skin (non exposed areas)?	Reddish	Very Pale	Pale with a beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None

**Total for Genetic Disposition:** \_\_\_\_\_

**REACTION TO SUN EXPOSURE**

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

**Total for Reaction to Sun Exposure:** \_\_\_\_\_

**TANNING HABITS**

Score	0	1	2	3	4
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

**Total for Tanning Habits:** \_\_\_\_\_

**Add up the total scores for each of the 3 sections for your Skin Type Score**

Skin Type Score	Fitzpatrick Skin Type
<b>0-7</b>	<b>I</b>
<b>8-16</b>	<b>II</b>
<b>17-25</b>	<b>III</b>
<b>25-30</b>	<b>IV</b>
<b>Over 30</b>	<b>V-VI</b>

**MUTUAL BINDING ARBITRATION AGREEMENT**

Patient's Name: \_\_\_\_\_

This mutual binding arbitration agreement constitutes an integral part of a contract for medical services by and between \_\_\_\_\_ (name of patient) and South Coast MedSpa/ Dr. Jagusch (name of physician) who agree to be bound as described hereunder:

1. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this Contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided in California law, and not by lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
2. Such arbitration shall be in accordance with the current arbitration rules of the American Arbitration Association. This Mutual Binding Arbitration Agreement shall apply to any legal claim or civil action in connection with any and all medical care or medical services rendered, whether inpatient or outpatient, against Dr. Jagusch or any of South Coast MedSpa's employees or contracted staff.
3. The execution of this Mutual Binding Arbitration Agreement shall not be a precondition of the furnishing of medical services by Dr. Jagusch/South Coast MedSpa. This Mutual Binding Arbitration Agreement may be rescinded by written notice from the Patient or Patient's legal representative within 30 days of signature.
4. **ALL CLAIMS MUST be ARBITRATED:** It is also understood that any dispute, including disputes not related to medical malpractice claims, shall be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, in contract, tort, or otherwise, including, but not limited to, all claims arising out of or pertaining to the treatment or services provided by South Coast MedSpa and its employees, physicians and management company. This agreement is intended to bind the patient and South Coast MedSpa and/or licensed health care providers (included nurses) or preceptor ship interns who now or in the future treat the patient while employed by, working or associated with South Coast MedSpa, including any employees working at South Coast MedSpa's facilities. The intention of the parties is that all claims for damages, in any form, must be arbitrated, including, without limitation, breach of contract, personal injury, wrongful death, loss of consortium, emotional distress, injunctive relief and/or punitive damages.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ A.M./P.M.

Signature: \_\_\_\_\_  
(patient/parent/legal guardian/legal representative)

If signed by other than patient, indicate relationship: \_\_\_\_\_



Consent for ActiveFX / Skin Care Laser Procedures

*Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure as outlined below. I will also inform South Coast MedSpa of any changes in my medical history, current medications and/or skin care products prior to any future treatments.*

I understand that the purpose of the ActiveFX / Skin Resurfacing is for improvements in skin tone (sun damage, dyschromia), skin texture (large pores, fine lines, acne scarring) and mild skin tightening.

I understand that the possible risks of the procedure include crusting, pain, swelling, redness, scarring, blistering, hypopigmentation, hyperpigmentation, increased skin vascularity and pigmentation as well as unforeseen complications. Due to the use of the intraocular eye shields eye injury and/or infection is possible but unlikely.

I understand that a single treatment will most likely not removal ALL of my dyschromia, sundamage, or texture problems in the area treated. Individual response will vary according to skin types, hair color, and degree of tanning, follow-up care, and the body area being treated.

I understand the treatment maybe painful, but is typically manageable without pain relief medication. For more aggressive procedures, talk to the Doctor about possible medication recommendations for pre and post treatment. Color changes such as hyperpigmentation or hypopigmentation may occur in the treated skin. This may take a few weeks to several months to resolve. Unprotected sun exposure in the weeks following treatments in contraindicated as it may cause or worsen this condition. Blistering of the skin may occur. Scarring of the skin can happen but is very uncommon.

I understand that the post-treatment symptoms may include but are not limited to the following: several hours (1-5) of a hot "sun burnt" feeling, swelling, extreme redness, pin point bleeding/scabbing, weeping/oozing, itching, acne breakouts (can last for weeks post treatment), extreme dryness, heat/sun sensitivity, nausea, bad odor to treated skin, etc.

I have revealed any medical conditions that may affect the laser procedure - such as pregnancy, cold sore tendencies, prone to post inflammatory hyperpigmentation, allergies, recent facial peels or surgery, types of contraindicated medications such as Accutane or use of Retin-A. Contraindicated medications should be discontinued five days prior and five days post laser treatment (unless otherwise indicated by your technician) Accutane must be discontinued for six months prior. I understand this procedure is considered cosmetic and as such is not covered by insurance. I understand that I am responsible for all costs of treatment and that there are no refunds for treatment.

PHOTOGRAPHS: I give permission for photographs to be used by the SCMS staff for educational purposes. Patient confidentiality will be maintained at all times. \_\_ (please initial)

! HAVE READ AND FULLY UNDERSTAND THE TERMS WITHIN THE ABOVE CONSENT. ALL MY QUESTIONS HAVE BEEN ADDRESSED T9 MY SATISFACTION. IN THE EVENT A DISPUTE ARISES OVER THE OUTCOME OF MY PROCEDURE, I CONSENT SOLELY TO ARBITRATION AS A LEGAL MEANS OF SETTLEMENT. I UNOERSTAND ENGLISH, OR IF I DO NOT, I HAVE APPOINTED SOMEONE TO TRANSLATE THIS CONSENT FORM IN ITS ENTIRETY.

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*Patient's Name (PRINTED)*

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*Patient's Signature*

-----  
*Date*

-----  
*Witness Name (PRINTED)*

-----  
*Witness Signature*

-----  
*Date*



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### Active FX/Skin Resurfacing Terms And Conditions

In an effort to ensure the best treatment available for Laser Skin Resurfacing the following terms and conditions apply to the Skin Care Package Purchased at South Coast Medspa.

1. Each individual will receive ( ) total treatments for the current price of \$\_\_\_\_.
2. Refer a friend and receive a complementary Microdermabrasion.
3. Each individual patient is responsible for the purchase of the skincare products associated with Laser Skin Resurfacing for the price of \$150.00. In addition each individual will buy the analgesic cream at the time of each treatment for the price of \$28 per container.
4. THE FEE FOR THE PROCEDURE IS NON-REFUNDABLE AND NON-TRANSFERABLE.
5. To avoid a \$100 cancellation fee, please contact us 48 hours in advance to cancel the scheduled appointment. NO EXCEPTIONS. \_\_\_\_\_ (initials)
6. Patients requiring bleaching cream must follow protocol to be treated at the time of the scheduled treatment.
7. Any extra areas not included in this package will be for additional costs.
8. Full treatment must be completed within 18 months of this agreement.

Print Full Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



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## **PAYMENT AUTHORIZATION**

I authorize South Coast Medspa to provide the treatment of

\_\_\_\_\_

On the date \_\_\_\_\_ for the amount of

\_\_\_\_\_ at the time of the visit.

All Sales are final and non-transferable.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Financially Responsible Party

\_\_\_\_\_  
Financially Responsible Party Signature