



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

**Medical History**

In order to provide you with the most appropriate laser hair removal or 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  No

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  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: \_\_\_\_\_

What Oral medications 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 medications 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

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 is 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 LASER HAIR REMOVAL**

(Print) Patient Name: \_\_\_\_\_

I understand that the purpose of this procedure is to remove unwanted hair. There are several alternatives to remove unwanted hair. There are several alternatives to laser hair removal treatment including but not limited to electrolysis, shaving, waxing and plucking.

I understand that the possible risk of the procedure include pain, purpura, swelling, redness, bruising, scarring, blistering, hyperpigmentation, mottling of skin vascularity and pigmentation and possible unforeseen complications. Eye injury is possible but unlikely, providing complete eye protection is properly used throughout laser treatment sessions.

I understand that a single treatment will not completely remove all of the unwanted hair in the treatment area. Multiple treatments are required. Individual response will vary according to skin types, hair type, hair color, degree of tanning, follow up care, and the body area being treated.

I understand the treatment may be painful, but this is typically manageable without any pain medication. Patients do have the option to use a triple acting numbing cream that can greatly reduce the discomfort associated with laser hair removal.

Color changes, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening), may occur in treated skin. This may take several months to resolve, if at all. Unprotected sun exposure in the weeks following treatments is contraindicated as it may cause this to worsen. Blistering of the skin may occur, scarring happens but is uncommon.

I further agree that any pictures or videotape taken of me may be used for either teaching or marketing and that all pictures are property of South Coast MedSpa. When pictures are used the patient identity is never revealed. If you wish to not have your picture used, is your responsibility to notify South Coast MedSpa in writing that you do not wish to have the photographs used prior to publication.

I understand the risk affiliated with this procedure and hereby hold South Coast MedSpa and any of its affiliates, harmless of any liability affiliated with this procedure or treatment. I have been asked at the time whether I have any questions about this procedure and do not. I understand the procedure, the risks, I accept the risk, and request that this procedure be performed on me by a qualified member of the staff of South Coast MedSpa.

**Please Check the Body Parts you wish to have Laser Hair Removal Performed on:**

- |   |                                     |                                    |
|---|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Upper Lip            | <input type="checkbox"/> Upper Arm  | <input type="checkbox"/> Lower Leg |
| <input type="checkbox"/> Chin                 | <input type="checkbox"/> Lower Arm  | <input type="checkbox"/> Feet      |
| <input type="checkbox"/> Full Face            | <input type="checkbox"/> Chest      | <input type="checkbox"/> Hands     |
| <input type="checkbox"/> Neck                 | <input type="checkbox"/> Abdomen    | <input type="checkbox"/> Ears      |
| <input type="checkbox"/> Underarms            | <input type="checkbox"/> Back       | <input type="checkbox"/> Shoulders |
| <input type="checkbox"/> Bikini (traditional) | <input type="checkbox"/> Buttocks   |                                    |
| <input type="checkbox"/> Bikini (Brazilian)   | <input type="checkbox"/> Upper Legs |                                    |

Patient Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner/Witness: X \_\_\_\_\_ Date: \_\_\_\_\_



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### Laser Hair Removal Terms And Conditions

In an effort to ensure the best treatment available for laser hair removal the following terms and conditions apply to the LASER HAIR REMOVAL Promo at South Coast Medspa. **ASK ABOUT OUR FAMOUS FULL BODY PACKAGE SPECIAL.**

1. Each individual will receive 6 total treatments for the current price of \$ \_\_\_\_\_
2. This package includes the following areas:  
\_\_\_\_\_
3. Refer a friend and receive a complementary Spot Treatment for every referral.
4. Your Spot Treatment rate for this package is only \_\_\_\_\_ per treatment for up to 5 years after the sixth treatment has been completed. Spot Treatments will be limited to the areas with hair only.
5. Each individual patient is responsible for the purchase of the skincare products associated with this treatment for the price of \$133.00. In addition each individual will buy the analgesic cream at the time of each treatment for the price of \$28 per container.
6. THE FEE FOR THE PROCEDURE IS NON-REFUNDABLE AND NON-TRANSFERABLE.
7. To avoid a \$100 cancellation fee, please contact us 48 hours in advance to cancel the scheduled appointment. NO EXCEPTIONS \_\_\_\_\_ (initials).
8. Arriving tanned to an appointment will also be considered a cancellation and this fee will also apply. NO EXCEPTIONS \_\_\_\_\_ (initials).
9. Any extra areas not included in this package will be for additional costs.
10. 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



## **Laser Hair Removal- Pre treatment (BEFORE)**

1. If you have a history of recurrent cold sores on the face or body, please notify us so that we may treat you with an appropriate medication prior to the treatment.
2. **Do not consider treatment if you are pregnant, plan to become pregnant or if you are breastfeeding.**
3. **Do not pluck, wax, use depilatory or undergo electrolysis in the areas you wish to have treated for 2 weeks prior to laser hair removal.**
4. **Do not tan the areas to be treated for 4 weeks prior to treatment.**
5. **Do not use self-tanning products for 2 weeks prior to treatment.**
6. Discontinue Accutane 6 months prior to treatment.
7. Discontinue Retin-A or glycolic products 2-5 days prior to treatment (if treatment is on the face).
8. Please notify us if you are taking blood thinners.
9. **You must come in clean- shaven- no stubble!**

## **Laser Hair Removal - Post Treatment (AFTER)**

1. **Avoid direct sun exposure for at least 5 days.**
2. Apply sunscreen –SPF 30- for 6 weeks over the treated area.
3. Some redness and swelling in the area is normal after treatment and may feel similar to a sun burn. This should resolve within several hours to several days after treatment. Skin cooling gel will help cool the area.
4. Gently clean area twice a day.
5. Avoid irritants (Glycolics, Retinoids, etc.) for seven days after treatment.
6. Avoid deodorants or body sprays of the skin for 24 hours.
7. Avoid exercise for 24 hours in most patients, however if the treated area remains red after 24 hours please avoid exercise until redness has resolved.
8. Avoid hot showers for 24 hours, shower with cool water.
9. Should redness persist or feel uncomfortable apply a cool compress to area.
10. Apply skin scrub in- between treatments( wait 24 Hours), to avoid ingrown hairs .
11. If you notice acne pimples please call 949-650- SCMS for medicine.

\* Personal and confidential information for South Coast MedSpa use only.