Patient History

[COMPANYLOGO_IMG]

Patient First Name: _____ **Patient Last Name:** _____

DOB: _____ dd / mm / yyyy **Patient ID:** _____

Please tick if the following applies

Please tick if the following applies

- [ ] Have you suffered from any acute skin disease, now or in the past?
- [ ] Do you have any general medical history? (eg Epilepsy, Diabetes, Hypertension, Pregnancy)
- [ ] Do you have a history of Keloid scars?
- [ ] Do you have or have you had any form of skin cancers?
- [ ] Do you have any Hormone abnormalities?
- [ ] Do you or have you ever suffered from coldsores? (eg Herpes simplex virus)
- [ ] Are you using aspirin or any blood thinning medication?
- [ ] Have you had any type of skin diseases? (eg Acne, Eczema)
- [ ] Do you have any type of immune deficiency? (eg HIV or Hepatitis)
- [ ] Do you have any allergies?
- [ ] Do you take any perscribed or non perscribed medication or herbal remedies? (eg St Johns wart)

TERMS AND CONDITIONS

For all patients a deposit of £500 will be required prior to booking an appointment for Earfold treatment. This deposit is non transferable. The deposit is non - refundable unless [COMPANYNAME] have received 1 weeks notice prior to the treatment of the appointment being cancelled.

Please note that you will be required to notify [COMPANYNAME] 1 week in advance of your treatment appointment should you wish to reschedule your appointment.

(Please note this is different to [COMPANYNAME] standard terms and conditons). Please note that cancellations can only be made between 09:00 – 19:00 Monday to Thursday and 09:00 – 17:00 Friday and Saturday 10:00 – 16:00. Out of hours messages will not be accepted.

Please state the type of treatment that you intend to have today (if unsure leave blank):

[COMPANYNAME] strive to provide the best appropriate medical care for all patients requiring aesthetic medical treatments, please can you indicate by completing the following section your reason for requiring aesthetic medical treatment today, which will help us to confirm that VAT is not applicable to your treatment.

The price quoted to you is on the basis that your treatment is for medical reasons and thus VAT would not be applicable.

Please tick if yes to the following

Please tick if yes to the following

- [ ] I am seeking treatment to improve my appearance
- [ ] My current appearance is reducing my confidence when interacting with others.
- [ ] If the problem with my appearance is improved I think my self-confidence will improve.
- [ ] If the problem with my appearance is improved I think my self-esteem will improve.
- [ ] If you have ticked no to all of the above, are you looking to improve your general well being?
- [ ] I confirm that all of the information I have given is accurate to the best of my knowledge and I will ensure that I advise my practitioner of any changes.
- [ ] My current appearance is causing my mood to be low
- [ ] If the problem with my appearance is improved I think that my mood will improve.
- [ ] If the problem with my appearance is improved I think that I will feel more confident when interacting with others
- [ ] The primary reason that I am seeking treatment is to improve my self-esteem, confidence and/or mood.
- [ ] The practitioner has explained the need for these medical treatments and I fully understand the implications.

Signature

First Name: _____ **Last Name:** _____

Date: _____ dd / mm / yyyy

This agreement is between clinic and hereafter known as the 'Patient'. I confirm that I have read and understood

I understand that [COMPANYNAME] will use their best efforts and judgment on my behalf.

I have read the information on these pages and I agree that this constitutes full disclosure and that is supersedes any previous verbal or written disclosure.

I certify that I have read and fully understood the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions.

I understand the treatment, contraindication, and possible side effects as explained by the Doctor, including bleeding, infection and permanent scarring.

I agree to allow [COMPANYNAME] to photograph or videotape me before, during and after the procedure. These photographs and videos shall be the property of [COMPANYNAME] and may be used for teaching, publication or scientific research. I understand that any surgical procedure is likely to result in a small scar and this has been discussed with me by my practitioner.

I have answered the questions put to me regarding my medical history to the best of my knowledge.

I confirm that I have also received the minor operation pre and post information sheets. Its contents have been explained to me and I will follow the advice given. I understand that immediately following treatment the area may appear reddened and that it is possible that scabbing/ crusting or swelling may occur.

I understand that exposure of a recently treated area to strong sunlight, without the use of a reputable sun block (SPF 30 or higher) or without first covering the treated area, should be avoided for at least three months.

No sun exposure is permitted in the treatment area for 4 weeks following treatment.

I understand that by agreeing to treatment I also agree to undertake all aftercare advice given to me by my practitioner.

My practitioner has explained the realistic expectations for my treatment and has informed me that RESULTS CANNOT BE GUARANTEED. I fully understand and accept them.

Please tick to the following

- [ ] have discussed my medical history fully with my practitioner
- [ ] My practitioner has advised me of the possible side effects or complications of my treatment related to the above medical conditions.
- [ ] I hereby consent to Earfold

I am signing this consent form prior to treatment and acknowledge that by signing this agreement, I fully understand its contents.

Patient Signature

Patient First Name: _____ **Patient Last Name:** _____

Date: _____ dd / mm / yyyy

Practitioner Signature

Practitioner First Name: _____ **Practitioner Last Name:** _____

Date: _____ dd / mm / yyyy