Patient Profile

Name: ____ DOB: _____________

Address: _________________________________ City: ___________ State: ______ ZIP: _________

Email address: ____

Home #:_____________________ Cell #:__________________ Work #:_______________

Emergency Contact:

Name: ___________________Phone: _________________ Relationship: _______________

How did you hear about GloMD? (Please specify)

Friend/Family Member: ____________________ Referring Physician: ____________________

Newspaper Ad: ___________________________ Internet: ___________________________

Other: ____

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

If yes, for what: _____________________ Physician's Name: ________________________

Are you on any medications (this includes hormones, blood thinners, birth control pills, antibiotics, anti-depressants, diuretics, etc.)?

If yes, please fill out the attached form. Yes No

Do you have an Allergic Reaction to any medications? Yes No

List Meds/reaction:

____

Do you have any allergies?

o Aspirin o Latex o Other

Do You Smoke? Yes No
Sometimes

Are you Pregnant? Yes No

Surgical Operations (when and why for each surgery):

____
____

Hospitalizations: (when and why for each admission):

____
____

Are you currently on Accutane or Differin Therapy? Yes No

If yes, when did you start?
____

Are you currently using; Renova, Retin-A, Tretinoin? Yes No

DO YOU NOW OR HAVE YOU EVER HAD:

Heart Disease/Heart Attack	Y	N	Family history: cancer, heart trouble, stroke	Y	N
Stroke	Y	N	Glaucoma	Y	N
Hypertension	Y	N	Other Eye Problems	Y	N
Low Blood Pressure	Y	N	Wear Glasses/Contact Lenses	Y	N
Sinus Problems	Y	N	Anxiety	Y	N
Asthma/Shortness of Breath	Y	N	History of Blood Transfusion	Y	N
Cancer	Y	N	Blood clot/DVT/pulmonary embolism	Y	N
Seizures	Y	N	Bleeding Tendency or Disorder	Y	N

Have you had any of the following in the last 7 days?

- Filler injection
- Botox
- Chemical peel
- Laser procedure

When was your last treatment?
____

Name: ___________________

Date of Birth: _____________

Medications

DATE	MEDICATION	DOSE	FREQUENCY	REASON

Patient Signature: ______________________________

Date: ____

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, doctor or nurse of my current medical or health conditions and to update this history.

Client Signature: ____

Date: ____

__ I have received a copy of GloMD's HIPAA Privacy Authorization Form

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

This form contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

As stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. As our patient, you have the following rights:

- To have access to and/or a copy of your health information,
- To receive and accounting of certain disclosures we have made of your health information;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

I have the right to revoke this consent in writing, at any time, except to the extent that GloMD has taken action in reliance on this consent.

My “protected health insurance” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

If you have any questions or concerns regarding our Privacy Practices, please contact our office at 978-475-7600. Or if you would like a more extensive description on our Privacy Policy, please ask at the front desk.

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Signature of Patient or Personal Representative   Date