

Medical History:

Who Referred You to Our Office? _____ Family Physician: _____

List All Medications Which You Now Take: _____

List All Allergies To Medications: _____

List All Other Known Allergies: _____

List All Surgery Within the Past 5 Years: _____

Female Patients Only: Are you taking oral contraceptives? Yes No

Are you pregnant or trying to become pregnant? Yes No

Check All Medical Conditions Which You Have Or May Have Had:

Basal Cell Carcinoma Squamous Cell Carcinoma of the skin Melanoma (Depth _____)

Blistering Sun Burns

Cancer (non skin) Type: _____ Date: _____ Treatment _____

Bleeding Tendency Diabetes HIV Heart Attack Hypertension

Stomach or duodenal ulcers hay fever hepatitis (type: _____) convulsions

Cataracts Glaucoma Asthma Eczema Psoriasis Lupus

Family History of skin disease: Yes Type: _____

Do you have an artificial heart valve, joint or other prosthesis that requires you to take antibiotics when you have dental procedures? Yes No If yes , what antibiotic _____

Are you allergic to Band-aids, tape or adhesive? Yes No

Have any members of your family had skin cancer? Yes No. If yes, what type? _____

Please list any other information that we need to know about: _____

We offer a full range of cosmetic procedures.

Please indicate whether you are interested in learning more about:

Botox Restylane Radiesse Sculptra Juvederm Perlane Intense Pulse Light Treatment

Lux IR Tightening Treatment Lux 1540 Rejuvenation Treatment Laser Hair Reduction

Treatment of Veins Custom Anti-aging Skincare Products Prevage MD Sunscreens

If any of these are of interest to you, please let us know and we can discuss them with you.

Would you like us to give you information regarding SpaCara and the treatments available? Yes No

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein.

SIGNATURE: _____ DATE: _____

Kenneth R. Beer, M.D., P.A. Board Certified Dermatology

Kenneth R. Beer MD * Jill S. Waibel MD Board Certified Dermatology

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Kenneth R. Beer, MD, PA
Kenneth R. Beer MD
Jill S. Waibel MD

Patient Consent For Use and Disclosure of Protected Health Information (PHI)

With my consent, Kenneth R. Beer, MD, PA; Kenneth R. Beer MD; Jill S. Waibel MD may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Kenneth R. Beer, MD, PA; Kenneth R. Beer MD; Jill S. Waibel MD Notice of Privacy Practices for a more complete description of such uses and disclosures.

Kenneth R. Beer, MD, PA; Kenneth R. Beer MD; Jill S. Waibel MD reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Kenneth R. Beer, MD, PA; Kenneth R. Beer MD; Jill S. Waibel MD at 1500 N. Dixie Highway Suite 305 West Palm Beach, FL 33401.

With my consent, Kenneth R. Beer, MD, PA; Kenneth R. Beer MD; Jill S. Waibel MD may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Kenneth R. Beer, MD, PA; Kenneth R. Beer MD; Jill S. Waibel MD may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Kenneth R. Beer, MD, PA; Kenneth R. Beer MD; Jill S. Waibel MD may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Kenneth R. Beer, MD, PA; Kenneth R. Beer MD; Jill S. Waibel MD restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am acknowledging receipt of Kenneth R. Beer, MD, PA's; Kenneth R. Beer MD; Jill S. Waibel MD Notice of Privacy Practices.

By signing this form, I am consenting to Kenneth R. Beer, MD, PA.; Kenneth R. Beer MD and Jill S. Waibel MD's use and disclosure of my PHI to carry out TPO.

Signature of Patient or Legal Guardian

Date

Patient's Name

DOB

Print Name of Patient or Legal Guardian

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and consent to use and disclose PHI to carry out TPO, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____
