MAGNOLIA MEDICAL & Aesthetics

19141 Stone Oak Pkwy., Suite 504
San Antonio, Texas 78258

COSMETIC INTAKE FORM: (Please print clearly)

All bold areas must be completed by adult (18+)

DATE: ___/_____/_____

Legal Name:_____
First: Last: M.I.

Nickname? _____ **Date of Birth**: _____ **Age**: _____ **Gender**: M F

Primary Address:_____**City**:_____ **State**: ____ **Zip**:_____

Primary Phone :(_____)_____Other: (___)_____ **Under 18?** Yes No

Occupation:_____

Email Address* (appointment confirmation, billing correspondence, advertising): _____@_____. _____
*may opt out of advertising emails via "unsubscribe" upon receipt of email

EMERGENCY CONTACT- Name: _____ Primary Phone: _____

Relationship to patient: _____

How did you hear about us/Referred by? _____

Please circle what you are interested in discussing today (Circle all that apply):

Acne	Dark Circles	Fine Lines/Aging	Microdermabrasion	Skin Care
Acne scarring	Dermaplane	Injectables	Microneedling	Sun Damage
Brown spots	Dry Skin	Laser Hair Removal	Oily Skin	Other_____
Chemical Peels	Fillers	Microblading	Redness on face	_____

*Please circle the areas on the face you would like to discuss/improve.

Medical History (Circle all that apply):

Acne	Eczema/ Psoriasis	Hormone Replacement	Skin Cancer _____
Auto Immune Disorder	Hearing Aid/Contact Lenses	Keloid scarring	_____
Bleeding Disorders	Heart Arrhythmia	Permanent Makeup	Other Conditions_____
Cold Sores/Herpes	Hepatitis B or C	Rosacea	_____
Diabetes	High Blood Pressure	Seizures	

Allergies: _____

Are you allergic to any of the following: Latex Lidocaine Tetracaine

Major Illnesses: _____

Surgical History: _____

Current Medications: _____

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Please answer yes/no to the following questions:

1. Are you currently being treated for any medical condition?	Yes	No
If so, please explain: _____		
2. Have you ever received Injectables or Fillers before?	Yes	No
If so, what type and what area:_____		
3. Are you currently pregnant or nursing?	Yes	No
4. Do you have any skin diseases or infections?	Yes	No
5. Have you used Accutane in the past 12 months?	Yes	No
6. Are you currently using Retinoids?	Yes	No
7. Are you currently on Blood Thinners?	Yes	No
8. Are you currently using Steroids?	Yes	No

9. What skin care products are you currently using?

_____

I confirm that the answers I have provided are true and I have not withheld any information that may be relevant to my treatment.

Patient/Guardian Signature_____ _____ **Date**_____

NOTICE TO PATIENT: THIS PAGE MUST BE FULLY COMPLETED/SIGNED

Physician-Patient Arbitration Agreement (PPAA):

I acknowledge that I have seen and read the PPAA:_____ *Copy available upon request.*
Initials

I acknowledge that I understand and agree to have any issue of medical malpractice decided by natural arbitration and understand my patient rights under the Physician-Patient Arbitration Agreement: _____
Initials

Signed by (print): _____ Date: ___/___/___ Physician/Authorized Office Personnel: Initials_____

Authorization to Contact Patient and Record of Disclosures (HIPAA):

The **HIPAA** privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (**check all that apply**):

___Okay to give detailed information via Voicemail, Email or Text
___Leave a message with office call back number only via Voicemail, Email or Text

___Other:_____

I authorize the release of protected health information to the individual(s) listed below:

Name:_____Phone: (___) _____ Relationship: _____

Name:_____Phone: (___) _____ Relationship: _____

I understand that I may revoke this authorization at any time by submitting a written request:

_____ _____
Patient/Guardian Signature **Printed Name of Patient/Guardian** **Date** ___/_____/____

I acknowledge that I have seen the Notice of Privacy Practices: _____ *Copy available upon request.*
Initial

I acknowledge that I have read and understand the Office Policies: _____ *Copy available upon request.*
Initial

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PATIENT CONSENT FOR MEDICAL PHOTOGRAPHS

I authorize Magnolia Medical & Aesthetics (MMA) to take/use medical photographs of myself or my child (or person for whom I am a legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, showing other patients before and after photographs, including but not limited to the practice website and social media pages, such as Facebook or Instagram.

I understand that I will not receive payment from any party for the use of my photographs.

Refusal to consent to photographs will in no way affect the medical care I will receive. I also understand that my treatment will not be conditioned upon my agreement to sign this authorization form.

I understand that I have the right to revoke this authorization, in writing, but I understand that any disclosure and release of my photographic images made prior to the time of such revocation cannot be recalled.

I hereby release and discharge Dr. Esquivel, MMA and their trustees, offices, employees, patients, and servants from any claims, demands, agents' actions, or causes of action against Dr. Esquivel or MMA for use of these images.
Federal law guarantees a patient's right to maintain privacy of medical information. Images, both still and motion taken before, during, and after medical procedures may be considered part of medical information.

I have read and understood the foregoing, and I have had the opportunity to ask any questions I have about this authorization to use my photographic images of my procedure.

Please check this box if you are comfortable with social media participation *Yes* ☐ *No* ☐

_____ Date (M/D/Y): _____/_____/_____
Signature of Patient

_____
Printed Name of Patient

_____
Witness (medical staff)

Post Procedure Follow-Up Waiver

In consideration of the risk and liability that exists in participation of procedures, Magnolia Medical & Aesthetics best practice recommends scheduling a follow-up appointment within 2-8 weeks post procedure. In signing this form, I agree to return to Magnolia Medical & Aesthetics within 2-8 weeks for a post procedure follow-up from the date of receiving procedure. Should I fail to return within that time frame, I hereby release Magnolia Medical & Aesthetics from any unwanted side effects or post procedure results. **I knowingly and voluntarily enter into this waiver and release of liability during time of signing, and throughout the continuation of my patronage at Magnolia Medical & Aesthetics.** Magnolia Medical & Aesthetics acknowledges that in the event of extenuating circumstances, some exclusions to this policy may apply on a case to case basis. Magnolia Medical & Aesthetics encourages following best practice for the best results. In signing this, I hereby acknowledge this and release liability should I dismiss best practice procedures.

Print Name: _____

Signature:_____ Date:_____

Allergan MEDICAL INSTITUTE
Advancing Excellence in **Facial Aesthetics**

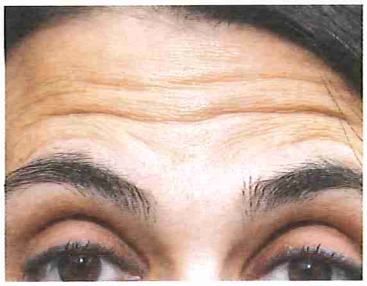
Patient Interest Questionnaire

Name: Age: Date: / /

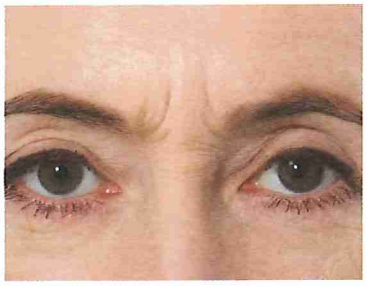
Please indicate any areas of concern for you

Check all that apply.

- ☐ Forehead lines

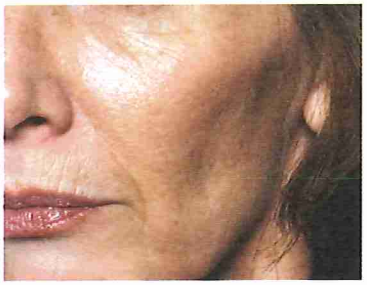


- ☐ Frown lines

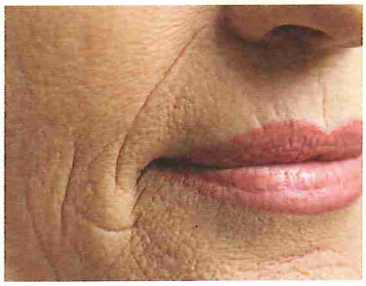


- ☐ Crow's feet lines

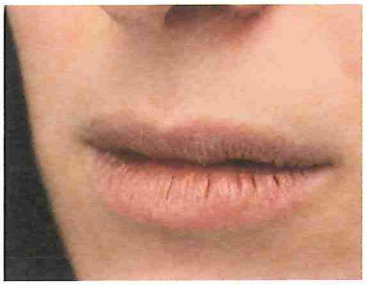
- ☐ Flattened cheeks/ sunken cheeks



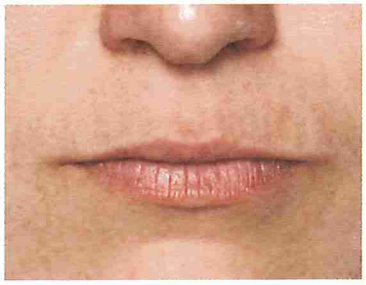
- ☐ Lines and wrinkles around the nose and mouth



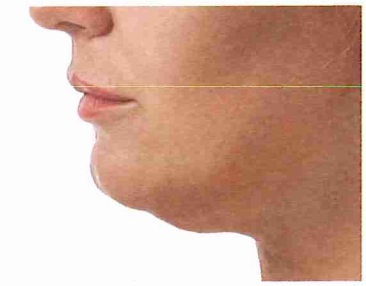
- ☐ Lip appearance and texture



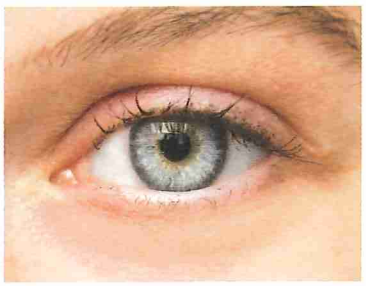
- ☐ Thin lips



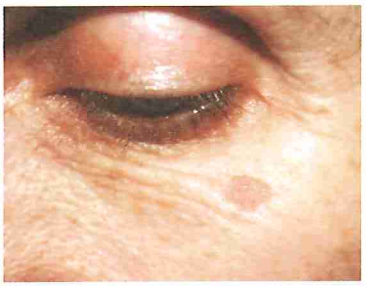
- ☐ Double chin



- ☐ Thinning or inadequate lashes



- ☐ Skin appearance and texture



Please complete questionnaire on back side.

Aesthetic specialist: See the next page to create the patient's treatment recommendations.

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Patient Interest Questionnaire

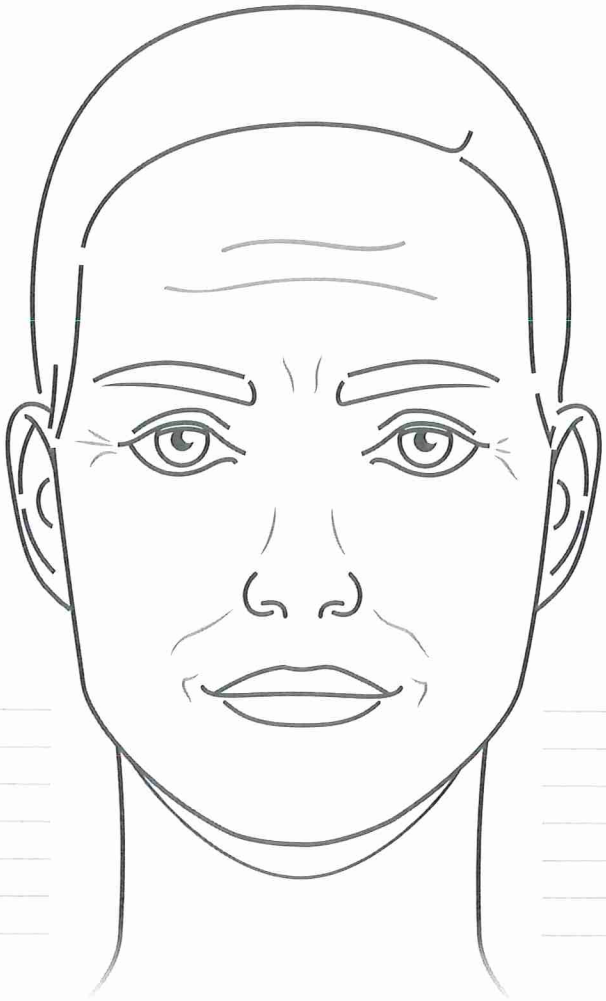
Share how you see yourself

I feel like I look:
Check all that apply.

- ☐ Sad
- ☐ Angry
- ☐ Tired
- ☐ Less lively
- ☐ Fearful
- ☐ Saggy
- ☐ Pained
- ☐ Less desirable
- ☐ Older than I feel
- ☐ Other _____

FOR USE WITH YOUR AESTHETIC PROVIDER

Evaluate concerns and aesthetic goals to customize each consultation



Patient name:

Next appointment date: / /