Weight, Wisdom & Wellness, LLC **TAX ID 46-1675799** **Dr. Jennifer Schmidt**
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New patient Visit – Medical History for Cosmetic Treatments

Name_____ D.O.B._____ Date:_____

Address: _____City:_____ State:_____ Zip: _____

E-Mail:_____ Phone:_____ Cell/Home/Work

ALLERGIES: _____
Have you EVER experienced an adverse reaction to Lidocaine or other anesthetic? YES or NO
If yes, what was the reaction?_____

MEDICATIONS:

Name of Medicine and strength?	How many pills?	How many times a day?	What condition are you taking it for?

Past Surgeries:_____

Do you Smoke or use Tobacco? ___NO ___ Never ___Not now (QUIT) - How Many Years Ago did you Quit? ____ years How many years did you Smoke for? _____ years
___ YES: How Many Packs per Day?_____ How many years have you smoked/used tobacco?_____yrs

Have you ever received Cosmetic Facial Treatments in the Past? YES or NO

If Yes, What Type? BOTOX Juvederm /Restlyn /Perlane
Other:_____

Would you like to be prescribed a numbing anesthetic cream called EMLA (a combination of Lidocaine 2.5% and Prilocaine 2.5%)? YES or NO

If Yes, What Pharmacy would you like to use?_____
****If you plan to use EMLA you should place the cream on the areas of your face to be injected one hour prior to your appointment time.**

- **Please do NOT take any Aspirin or NSAIDS (Ibuprofen, Advil, Aleve) for 7 days prior to Juvederm injections or 48 hours prior to Botox injections.**
- **Please go to: www.juvederm.com or www.botoxcosmetic.com and view the patient information regarding these treatments prior to your appointment. Please call with any questions.**

Notice of Privacy Practices – Dr. Jennifer M. Schmidt

As part of your contract for services with our healthcare provider we are required to provide you with a notice of the policies and practices we employ regarding the use of your healthcare information.

We may collect information about your current or past health conditions, medications, laboratory results, imaging tests, consultations, personal social, dietary, exercise habits and treatment plans for the purpose of evaluating your health risks, developing and implementing treatment plans, coordinating your healthcare and receiving payment for our services.

We may share your information with other people involved in your healthcare such as healthcare providers, healthcare institutions, insurance companies, laboratory service providers, family members and your employer. We are required by law to notify pharmaceutical companies and the FDA if you experience a severe adverse reaction to a medication. We may use or disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. We may exchange or store your health information in written form, by fax; mail or electronically, this may include the use of secure cloud based Internet services. We will use due diligence to keep your healthcare information confidential at all times and in all forms. We will employ the use of passwords, encryption and other security measures to keep your information safe. In the event that there is evidence that your healthcare information has been compromised we will notify you within 30 days from the date we were made aware of the possible breach. It is your responsibility to keep your contact information up to date.

We may contact you regarding appointments, test results or to let you know about health-related services or products that you may be of interest to you.

You may revoke your authorization in writing at any time. You may request that we do not share your healthcare information with specific individuals or entities. You must make this request in writing and specify by name which individuals or entities we should not share your information with, the date of your request and for how long this request applies. We are unable to take back disclosures that were already made with your authorization. We are required to retain copies records of your care for a period of 7 years.

You have the right to ask that we add an amendment to your health records if you believe that a piece of important information is missing or incorrect. You must make this request in writing and it must include the reason for your request. By United States law we are not able to delete any information from your records that we believed to be accurate at the time of its creation.

By signing below, I acknowledge the receipt of the above notice of privacy practices and I have had the opportunity to ask for clarification about these policies.

Patient Name_____ D.O.B._____ Date:_____

Patient Signature_____ Witness Signature_____