EnteBella
15425 N. Scottsdale Rd. Suite 120
Scottsdale, AZ 85254
480.278.7233

PATIENT INFORMATION:

PATIENT'S NAME: _____ DATE OF BIRTH_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

FOR MARKETING PURPOSES:

HOW DID YOU HEAR ABOUT ENTEBELLA? CIRCLE:

TV RADIO INTERNET FACEBOOK

TV, WHAT CHANNEL? CIRCLE:

ARIZONA MIDDAY YOUR LIFE A TO Z SONORAN LIVING

FRIEND OR FAMILY MEMBER: _____

IF A DOCTOR SENT YOU HERE, WHAT IS THE DOCTORS NAME?

_____

WOULD YOU LIKE EMAILS REGARDING MONTHLY SPECIALS SENT TO YOU?

YES _____ NO _____

PATIENT'S SIGNATURE: _____ DATE: _____

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Medical History:

Do you have or have you ever been treated in the past for:

Migraines or other headaches?	Yes	No
Stroke/TIA?	Yes	No
Carotid Artery Disease (blockages in the neck arteries)?	Yes	No
COPD/Emphysema?	Yes	No
Asthma?	Yes	No
Other Respiratory/Lung Conditions?_____		
High Blood Pressure?	Yes	No
High Cholesterol?	Yes	No
Coronary Artery Disease?	Yes	No
Heart Attack? (If yes, when?)_____	Yes	No
Other Heart Conditions?_____		
Thyroid Problems?		
Diabetes?	Yes	No
GERD?	Yes	No
Kidney Disease/Kidney Failure/Kidney Transplant?	Yes	No
Gout?	Yes	No
Arthritis?	Yes	No
PVD/PAD? (If yes, type and treatment)_____		
Cancer? (If yes, type and treatment)_____		

Other Medical/Health Conditions not listed above?

_____

_____

What surgeries have you ever undergone in your lifetime?_____

_____

Skin Type Form

Skin type is often categorized according to the Fitzpatrick skin type scale, which ranges from very fair (skin type I) to very dark (skin type VI). The three main factors that influence skin type and the treatment program:

Genetic disposition ***Reaction to sun exposure*** ***Tanning habits***

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes color of eyes, hair, etc. The way your skin reacts to sun exposure is another important factor in correctly assessing your skin type. Recent tanning (sun bathing, artificial tanning or tanning creams) has a major impact on the evaluation of your skin color. Please help us determine your skin type and treat you the right way. Please take a few minutes to fill-out this questionnaire, ***circling the most appropriate response***.

Genetic Disposition

Score	*0*	*1*	*2*	*3*	*4*
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Hazel/ Brown	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut/ Dark Blond	Dark Brown	Black
What is the color of your skin (non-exposed areas)?	Reddish	Very pale	Pale Beige tint	Light Brown	Dark Brown
Do you have freckles on **unexposed** areas?	Many	Several	Few	Incidental	None

Score for Genetic Dispositi ☐

Reaction to Sun Exposure

Score	*0*	*1*	*2*	*3*	*4*
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely burns	Never burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very Sensitive	Sensitive	Normal	Very resistant	Never had a problem

Score for Reaction to Sun Exposu ☐

Tanning Habits

Score	*0*	*1*	*2*	*3*	*4*
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
When in the sun, do you expose the area to be treated?	Never	Hardly ever	Sometimes	Often	Always

Score for Tanning Habi ☐

What color is the hair in the area to be treated?_____

	⬅ Genetic Disposition Score	**Skin Type Score**	**Skin Type**	**Skin Color**
	⬅Reaction to Sun Exposure Score	0-7	I	Very fair, "transparent"
	⬅Tanning Habits Score	8-16	II	Fair
	⬅Total Score	17-25	III	Fair to light olive
	⬅Skin Type	26-30	IV	Olive to brown
		Over 30	V-VI	Dark Brown - Black

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Patient Record of Disclosures

In general, the HIPPA 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):

[ ] Home Telephone _____
[ ] Ok to leave message with detailed information
[ ] Leave message with call back number only

[ ] Written Communication
[ ] Ok to mail to my home address
[ ] Ok to mail to my work/office address
[ ] Ok to fax to this number

[ ] Work Telephone_____
[ ] Ok to leave message with detailed information
[ ] Leave message with call back number only

[ ] Other _____
_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to who Address or Fax number		By whom Disclosed		

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NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about our patients may be used and disclosed. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996. (HIPAA). This notice is effective as of 4/14/03 and will remain in effect until we replace it.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
We realize these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or a law enforcement official.
8. For Workers Compensation and similar programs.
9. To remind you of needed appointments in the near future by way of a mailed postcard.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in the patient's care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, please ask the front desk receptionist.
4. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable laws.

If you have any questions regarding this notice please ***let us know!!!***

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices for EnteBella of Scottsdale.

Signature of Patient _____ Date:_____