Gabbert Medical
120 E. Main Street, Suite B |Payson, Az 85541
P: 928-472-2225 | **F:** 928-468-0002
www.GabbertMedical.com

Aesthetics

NEW PATIENT INTAKE FORM

(Patient Demographic)

Patient Name: _____Nick name/AKA: _____
Date of Birth: _____Age: _____Gender: _____Male _____Female _____
Address: _____City: _____State: _____ Zip: _____
Cell phone: _____Home phone: _____Best contact #: ☐ Cell ☐ Home
How did you hear of the clinic? _____
Email Address: _____ (*for appointment or billing information*)

Occupation: _____ Employer: _____ Hrs per week: _____
Employer's phone number: _____Highest level of education: _____
Emergency contact's name: _____Relationship: _____
Emergency contact phone number: _____ (Secondary number): _____
Regular Physician: _____ Phone number: _____
Height: _____Weight: _____ Nationality: _____

(Medical History)

Have you taken Antibiotics in the last year? Yes ☐ ☐ No When? _____

Please list any of the following as current or previous conditions:

Allergies: _____
Skin Infections: _____
Cold Sores: _____
Other: _____

List any current medications including Aspirin, Ibuprofen, supplements/remedies, blood thinners, fish oil, etc.:

1._____ 3. _____
2._____ 4. _____

In the past 48 hours, have you used Alpha Hydroxy Acid products? Please list name brand(s):

1._____ 3. _____
2._____ 4. _____

In the past 2 weeks, have you used products like Retin A, Renova, salicylic acid, alpha/beta hydroxy/glycolic?

_____ _____
_____ _____

(Medications/Allergies)

Are you pregnant or nursing?: ☐ Yes ☐ No

What medications do you take daily, how often and what dosage?

1._____ _____times a day. Dosage:_____

2. _____ _____times a day. Dosage:_____

3._____ _____times a day. Dosage:_____

**Are any of the medication(s) you take anti-inflammatories or anti-coagulants? ☐ Yes ☐ No

Do you have a history of seizures? Yes ☐ No ☐

Please List All Sensitivities/Allergies/Reactions

Drugs: _____

Foods: _____

Environment: _____

**Have you ever been diagnosed with or treated for active cancer? ☐ Yes ☐ No

**At this time, are you currently sick or fighting off any viral infection(s)? ☐ Yes ☐ No

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(Skin Assessment)

Have you ever had any facial surgeries? _____

Have you had any sun exposure in the past 2 weeks? _____

Have you tried Accutane? _____

What treatments have you tried that have **NOT** worked? _____

_____

_____

Check all concerns that apply to you:

☐ Acne ☐ Wrinkles ☐ Dry Patches ☐ Rosacea ☐ Scarring ☐ Enlarged Pores ☐ Clogged Pores

☐ Uneven Skin Tone ☐ Black/White Heads ☐ Excessive Oiliness ☐ Hard Bumps Under Skin ☐ Skin Laxity

☐ Unwanted Hair ☐ Upper Lip Lines ☐ Brown Spots ☐ White Spots

Other: _____

What is your skin type? ☐ Dry ☐ Combination ☐ Oily ☐ Normal

Please email the completed forms to info@gabbertmedical.com
OR print the completed forms and bring them to your appointment.

(Skin Continued)

Please check the products you currently use, how often and list the name brands:

- ☐ Facial Cleanser _____
- ☐ Toner _____
- ☐ Growth Factors _____
- ☐ Retinol _____
- ☐ Antioxidant _____
- ☐ Moisturizer _____
- ☐ Sunscreen _____
- ☐ Anti-Aging Serum _____
- ☐ Eye Cream _____
- ☐ Scrub _____

Do you use any products (topical or oral) for acne, skin cancer, anti-aging or hyperpigmentation?
Please list: _____

_____

_____

_____

Have you ever tried any of the following injectables or implants:

☐ Botox ☐ Juvederm ☐ Radiesse ☐ Restylane ☐ Perlane ☐ Collagen ☐ Bellafill
☐ Sculptra ☐ Dysport ☐ Other:

_____

If so, when was the procedure(s) done? _____ What area(s)? _____

_____

_____

Have you had any other cosmetic surgeries/procedures? _____
When? _____
Were you pleased with the results? _____

Please mark any services you would like more education on:

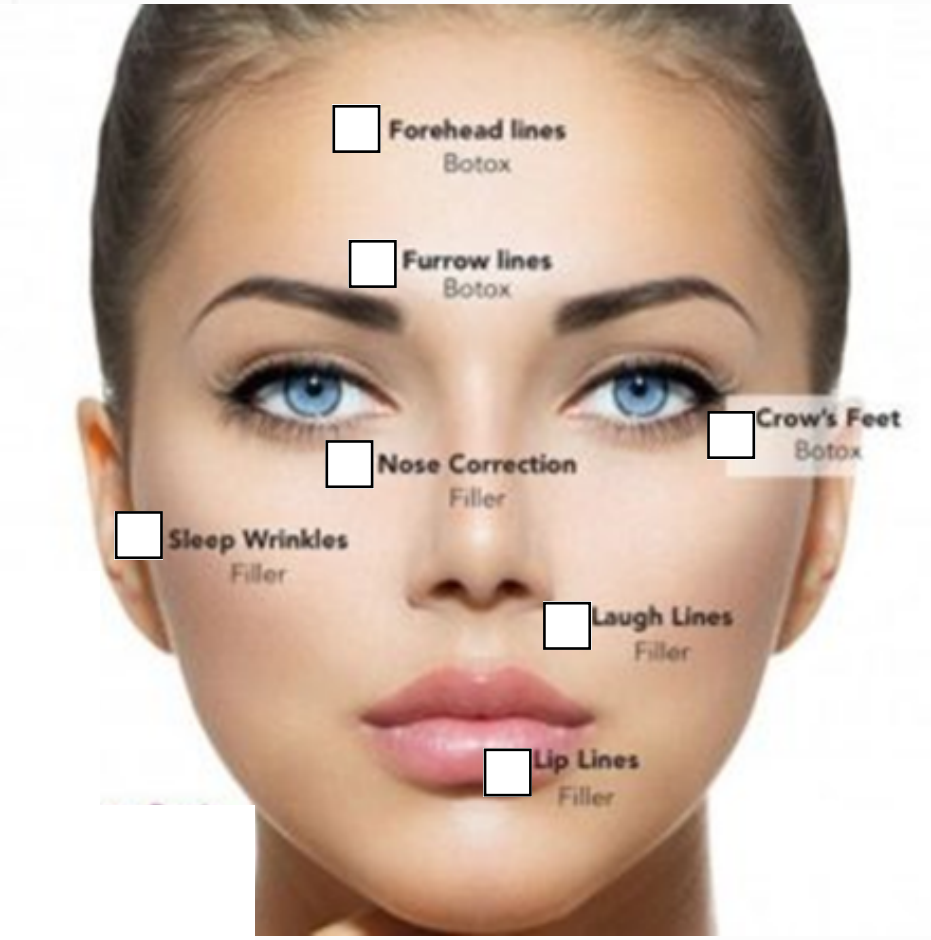
_____

- ☐ Physician Grade Skincare
- ☐ Microblading (For eyebrows)
- ☐ Mineral Makeup
- ☐ Lip Augmentation
- ☐ Laser Hair Reduction
- ☐ Pelleve Skin Tightening
- ☐ Medical grade Skin Peels
- ☐ DNA Genetic Testing
- ☐ Sclerotherapy
- ☐ Microneedling with PRP
- ☐ Injectables (Botox, fillers, etc.)
- ☐ Novathreads (Facial thread lifts)
- ☐ Liposuction
- ☐ Facials
- ☐ Sunless Tanning
- ☐ Weight Loss / Hormone Therapy

How important is renewing your quality of life? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

(0 not urgent - 10 absolute must)

CIRCLE THE AREAS OF CONCERN BELOW:



Thank you for taking the time to complete our New Patient Intake form. With the information provided, we will be better able to serve you. Our goal is to provide you with excellent service and results that you love.
At future visits please let us know if any of your information changes. All information and treatments are confidential.

Cancellation Policy

It would be greatly appreciated if appointments need to be canceled, rescheduled, or the appointment type changed, that it be done at least 24 hours in advance. Should you fail to give us 24 hours' notice to cancel or alter your appointment; a cancellation fee of $50 WILL be charged to the credit card on file OR a deposit for the full cost of future services will be required at the time of booking.
Initial that you have read and agree: _____

Payment Policy

We are committed to the success of your medical treatment and care. Please understand that payment for your services is part of your treatment and care. You will be responsible for the FULL payment the time of service. If a deposit is required, that will need to be paid prior to the scheduled appointment. If you need further information regarding our payment policy, please ask to speak with the practice or front office coordinator.
Initial that you have read and agree: _____

I understand that the results are not guaranteed. There are many variables that are beyond our control that affect the procedure outcomes, especially individual expectations. We maintain our equipment and continue staff education and training regarding technique. There are times when the human body does not respond as well as we would like. Lifestyle choices, diet, exercise, hydration, prior skin damage, sun exposure and many other factors affect the final results. All our patients are unique and have unique needs and expectations. Please discuss your treatment expectations with us prior to your treatment because there are NO refunds.
Initial that you have read and agree: _____

Patient/Representative Signature: _____ Date: _____

Provider/Office Representative Signature: _____ Date: _____

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OFFICE POLICIES

OFFICE HOURS

Our office is open Monday-Thursday 9:00 am to 6:00 pm and Friday by appointment only. Patients are not scheduled from 12:30 pm through 2:00 pm during lunch. We are closed in observance of all major holidays.

NEW PATIENTS

For purposes of maintaining continuity of care, we ask that first time patients bring us the latest relevant records with the most recent test results, MRI / CT / XRAY/BLOOD WORK and current medications list. We do ask that you remain the sole custodian of your entire medical records from your previous healthcare providers. Should there be a need to further examine your previous records; our providers will have you bring your records back for additional review during subsequent office visits.

COURTESY

We strive to provide the best medical care for our patients. While we make every effort to provide prompt on-time service, the healthcare needs of each individual do not necessarily lend themselves to an exact schedule. We therefore appreciate your understanding and patience if you have to wait a few extra minutes. If you have any suggestions or complaints for our office, please let us know. Angry or foul language directed to our staff regardless of the issues involved will absolutely not be tolerated and will be grounds for immediate dismissal from our practice.

SUPERVISION OF CHILDREN & MINORS PRESENT WITHOUT PARENTS OR LEGAL GUARDIAN

Although we provide an area for children to entertain themselves, for safety reasons, we depend on parents to properly supervise their child(ren) at all times. Our staff cannot watch your children. Under no circumstances should a child under the age of 10 be left unattended. We also require a consent form signed by a parent or legal guardian to legally provide medical care to minors 16 and 17 years of age when the parent or legal guardian cannot be present. Minors 15 years of age or younger must be accompanied by a parent or legal guardian.

CHANGES IN ADDRESS, BILLING, OR CONTACT INFORMATION

Please notify our office in writing of any changes of address, telephone, billing or contact information. It is imperative that we have the most current information on file.

FEES & PAYMENTS

Prices/Fees are subject to change. Payment in full is due at the time services are rendered. We do not except any forms of insurance. We accept credit/ debit cards, cash, personal check, cashier's checks, HSA cards. A copy of your driver's license or photo ID will be taken for your file on record. Should you require a payment plan, our office manager will be glad to discuss your options with you.

Balances over 120 DAYS due may be sent to a collection agency unless other arrangements have been made. A $50 fee may be assessed on accounts placed in collections. We may also elect to discharge you from our practice should you fail to comply with our policy.

APPOINTMENTS AND NO SHOW

We make every effort to provide prompt medical care to all of our patients. If you are unable to keep a scheduled appointment, please let us know at least 24 hours in advance. A NO SHOW is when a patient fails to keep a scheduled appointment and does not give an appropriate amount of notice time. If you are scheduled for IV and or Injection therapy and no show, a fee may be assessed to cover the cost of wasted product if the IV or injection was pre-made. Fees will be assessed as follows, IV-$100.00 / Injection-$20.00 In the event that you have a special circumstance regarding your missed appointment, please contact our office manager. We understand that there may be issues beyond your control and want to be understanding of special circumstances.
If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Any significant delay may require the visit to be rescheduled.
Should you have more medical issues that need to be addressed, please inform our staff when calling for appointments, and we will schedule more time for you accordingly. Multiple family member appointments must be scheduled in advance. Family members who are present at the time of another member's appointment, but are not scheduled, may be required to schedule an appointment at a later time.

TELEPHONE MESSAGES & PROCESSING OF REFERRALS

We will try our best to respond to your messages as soon as possible. However, please be aware that messages may take up to 24 HOURS to process and respond. More often than not, if your questions require extensive attention, the doctor may elect to have you make an appointment and come for further evaluation for quality assurance purposes.

MEDICAL RECORDS & FORMS

All requests for medical records must be on a HIPPA approved form, which must be properly and completely filled out and signed by the patient or legal guardian. Improperly filled out forms may delay your request. Please allow at least 10 BUSINESS DAYS for processing.
Medical records released to a new provider, specialist or school: For continuity of care and as a courtesy to the patient, our office will forward records requested at no charge.
Medical records released to the patient, some insurance companies, law firm or miscellaneous requests: Records are subject to copying fees.

IN A LIFE THREATENING SITUATION, PLEASE CALL 911 IMMEDIATELY.

Our friendly staff is committed to making your visit as pleasant as possible. Your comments or concerns are important to us. We rely on them to continue to improve our quality medical care to you and your family.

By signing below, I understand and agree to the office policies and procedures explained above. A copy of the office policies and procedures along with notice of privacy information regarding Gabbert Medical will be available to me upon request.

Patient Print Name: _____ **Date:** _____

Patient Signature: _____

Parent/Guardian Signature required if patient is under the age of 18.