Rhonda K. Bowen, D.D.S., PLLC

www.rhondakbowendds.com

(719) 599-5185

Botox/Fillers/Injectables/Laser Therapy/Skin Care History

Name:_____ Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Email Address:_____ SSN#:_____

Home Phone:_____ Cell:_____ Work:_____

May we contact you at home, on your cell, or at work?_____

Date of Birth:_____ Age:_____ Gender:_____ Marital Status:_____

Height:_____ Weight:_____(lbs) How did you hear about our office?_____

Race: Caucasian African American Hispanic Asian Other:_____

Reason for visit, why are you here today?_____

What conditions/problem areas would you like improved: (check all that apply)

__ Sun damage	__ Brown spots/uneven skin	__ Dry patches
__ Clogged pores	__Acne/pimples	__Unwanted hair
__ Scarring	__Wrinkles	__ Dermatitis
__ Excessive oiliness	__Blackheads/whiteheads	__ Rosacea
__ Upper lip lines	__ Freckles	

How much time do you spend in the sun?_____ Do you use Tanning Beds?☐Yes☐No

Do you wear sunscreen?☐Yes☐No How often?_____ SPF/Brand_____

How would you describe your skin?_____

In the sun, do you?☐Always burn ☐Sometimes burn ☐Sometimes tan ☐Never burn ☐Always tan

Any allergies to medications?_____

Any history of anaphylactic or allergic reaction(s)?____ If yes, please explain:_____

_____

Bad reaction to cosmetics: ☐Yes ☐No If yes, what brand?_____

Any allergic reaction to Botulinum Toxin (Botox):☐Yes ☐No If yes, what brand?_____ Latex Allergy? ☐Yes ☐No

Are you allergic to albumin (eggs)?☐Yes☐No Are you allergic to cows milk?☐Yes ☐No Are you allergic to lidocaine?☐Yes☐No

Are you allergic to gram positive bacteria proteins? ☐Yes ☐No Any history of swallowing problems? ☐Yes ☐No

Are you pregnant or breast feeding?_____ Amount of water you drink a day:_____ 8oz glasses

Please list any medical conditions:_____

_____

_____

Physician Name:_____ Phone Number:_____

Have you ever had any of the following conditions:

☐ Abnormal heart rate	☐ Dermatitis	☐ Immune disorders	☐ Rosacea
☐ AIDS	☐ Diabetes	☐ Keloid scars	☐ Skin cancer
☐ Anemia	☐ Dizziness	☐ Kidney disease	☐ Sinus problems
☐ Arthritis	☐ Epilepsy	☐ Liver disease	☐ Stomach problems
☐ Asthma	☐ Eczema	☐ Lupus	☐ Stroke
☐ Bleeding disorder	☐ Fainting	☐ Melanoma	☐ Thyroid problems
☐ Blood disease	☐ Fibromyalgia	☐ Nervous disorder	☐ Tuberculosis (TB)
☐ Blood transfusion	☐ Hay fever	☐ Neuromuscular disorder	☐ Urinary problems
☐ Cardiac problems	☐ Heart disease	☐ Pacemaker	☐ Ulcers
☐ Chemotherapy	☐ Hepatitis	☐ Psoriasis	☐ Venereal disease
☐ Chronic headaches	☐ High blood pressure	☐ Radiation treatment	☐ ****Cold sore/Fever blister**
	☐ Infection (active)	☐ Respiratory disorder	**Frequency _____ times/year**

List all medications you are presently taking (including over-the-counter products, vitamins and supplements)**:** _____

_____

_____

Previous Cosmetic Facial Treatments, Surgery, Resurfacing, or Laser Treatments:

__ Acid peels Date:_____ __ Fillers/Injectables Date:_____

__ Botox Date:_____ __ Laser surgery Date:_____

__ Waxing Date:_____ __ Facial plastic surgery Date:_____

__ Tattoo/Perm makeup Date:_____ __ Microdermabrasion Date:_____

I have answered the above questions truthfully and will notify you of any changes in medications and physical conditions.

Patient Signature:_____ **Date:**_____

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Treatment Consent, Release of Information, Financial Agreement

TREATMENT CONSENT: I understand and acknowledge that Colorado Law provides that if any health care worker is exposed to my blood or bodily fluid, this practice may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including HIV, with or without my consent. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of this practice. I understand the results of tests taken under these circumstances are confidential and do not become a part of my medical record. I give my consent to Dr. Rhonda K. Bowen or her designees to perform or administer all tests and treatment that, in the judgement of Dr. Rhonda K. Bowen, is advisable during my visit to this practice.

RELEASE OF INFORMATION: I authorize to release/obtain information contained in my financial and medical records, including diagnosis and test results, to/from (a) any of my treating practitioners, (b) my insurance company or health care plan or its representative, or its agents or independent contractors or (c) any person or entity that is responsible for paying or processing for payment any portion of my medical treatment bill or (d) to any person or entity for the purposes of administration, billing, collecting, and quality assessment and risk management or to any hospital, nursing home, home health agency or to any healthcare institution to which I am transferred. I understand this consent applies to all records created in course of and relating to my care. I release and agree to hold harmless the practice of Dr. Rhonda K. Bowen and her representatives and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand this practice cannot be responsible for use or redisclosure of information third parties.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: In consideration for the medical services to be or have been rendered to me, I agree to pay for those services. I agree to assign to Dr. Rhonda K. Bowen, the benefits under my insurance policies or prepaid health care plan or other reimbursement source. I acknowledge that any balance not covered or paid by such policy or plan is my legal and financial responsibility. I acknowledge that I am aware this practice does not charge interest for late payments. I acknowledge that I am aware that any balance not covered or paid after 120 days, will be turned over to a collection agency and this practice will initiate termination of my patient-physician relationship as described by Colorado Law. I acknowledge that any billing related complaint will be directed to the billing compliance officer. I acknowledge and I am aware that cosmetic surgery procedures are not covered by the benefits under my insurance company and Dr. Rhonda K. Bowen does not accept insurance reimbursements for cosmetic surgery procedures and all charges related to cosmetic surgery are my own financial responsibility. I understand that there is a $35 NSF for all returned checks. I acknowledge that I am aware the policy of billing practices and the policy of charity care are both available upon request.

THIS IS A LEGAL CONSENT, FINANCIAL AGREEMENT, AND ASSIGNMENT OF BENEFITS FORM. PLEASE READ IT CAREFULLY AND BE SURE YOUR QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING.

Patient Signature:_____ Date:_____

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Photographic Consent

Full Name:_____ Date:_____

I, _____, hereby authorize and consent that any and all photographs, images, or videos taken by Dr. Rhonda K. Bowen of any part of my body, whether originals or reproductions, may be utilized for such purposes as she may desire in connection with his research, writing, professional activities, and may be used, exhibited and published through any medium whatsoever as part of or in connection with her research, writing, and professional activities, even though such use may be for advertising purposes or purposes of trade. This consent is not retractable, either by oral or written means.

I certify that I have read and understand the aforementioned and sign my name below giving authorization and consent to the foregoing and any photographs, image, or videos taken for future procedures.

Patient Signature:_____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

Health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice maybe changed at any time. I may obtain a copy of the Notice by requesting one at this office.

Do you have any restrictions as to how we contact you?_____

Special Instructions:_____

_____

Signature:_____

Patient Name:_____

Date:_____

If signed by a personal representative, please state your authority to act for the patient

****FOR OFFICE USE ONLY****

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify):_____