DermaTouch RN **Skin Typing**

NAME _____ **DATE** _____

Please answer the following questions by circling the number which best describes you. Your clinician will total the score during the consultation.

My ethnic origin is closest to: (check one)	I. Very fair (Celtic and Scandinavian)	
	II. Fair-skinned Caucasians with light hair and light eyes	
	III. Pale-skinned Caucasians with dark hair and dark eyes	
	IV. Olive-skinned (Mediterranean, some Asian, some Hispanic)	
	V. Dark-skinned (Middle Eastern, Hispanic, Asians, some Africans)	
	VI. Very dark-skinned (African)	
My eye color is:	Light blue	0
	Blue/green	1
	Green/gray/golden	2
	Hazel/light brown	3
	Brown	4
My natural hair color at age 18 was:	Red	0
	Blonde	1
	Light brown	2
	Dark brown	3
	Black	4
The color of my skin that is not normally exposed to sun is:	Pink to reddish	0
	Very pale	1
	Pale with a beige tint	2
	Light brown	3
	Medium to dark brown	4
	Dark brown-black	6
If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:	Burn, blister and peel	0
	Burn, then when the burn resolves there is little or no color change	1
	Burn, but then turns to tan in a few days	2
	Get pink, but then turns to tan quickly	3
	Just tan	4
	Just gets darker	5
	My skin color is so dark I can't tell	6
When was the last time the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?	Longer than one month ago	0
	Within the past month	1
	Within the past two weeks	3
	Within the past week	4
	Total Score:	

If your score is:	**Your skin type is:**	**Notes:**
0 – 3	I	
4 – 7	II	
8 – 11	III	
12 – 15	IV	
16 – 19	V	
20 – 24	VI	

DermaTouch RN

New Patient Information

Name: _____ **Birth Date**: _____/_____/_____**Age:**_____
Address: _____ **Sex: M / F**
City: _____ **State:** _____ **Zip Code:** _____
Home: (_____)_____ **Work:** (_____)_____ **Cell:** (_____)_____
E-mail: _____
Emergency Contact: _____ **Telephone:** (_____)_____
Allergies: _____
LMP (women): _____
How did you hear about DermaTouch RN? (please check all that apply) ;
Email_____, Web_____ (Where and key words used_____), Referral____ (Name of person who referred you_____)

Please put a check mark next to the procedures about which you would like to receive more information:

___ Acne Treatment
___ Botox to Flatten and Prevent Wrinkles
___ Enhanced Skin Rejuvenation
___ Collagen Augmentation
___ Wrinkles
___ Skin Toning or Pore Size Reduction
___ Facial Redness
___ Brown Spots
___ Sun Damage
___ Broken Capillaries
___ Spider Veins/Leg Veins
___ Hair Reduction
___ Shaving bumps/ingrown hair
___ Radiesse, Juvederm, or Restylane

Please put a check mark next to a past or current medical condition:

Medical History:

___ Lupus or other auto-immune deficiency
___ Rheumatoid Arthritis "Gold" Therapy (A)
___ Currently Pregnant (A)
___ Bleeding abnormalities (A)
___ Treatment with Accutane® in the last year (A)
___ Treatment with Tetracycline® in the last month(A)
___ Keloid or very thick scarring (A)
___ Psoriasis or Vitiligo (A)
___ Pulmonary embolism/blood clot (V)
___ Leg ulcer or Phlebitis (V)
___ Blood thinning medication (V)
___ Coumadin/anti-clotting agents (A)
___ Cystic Acne (P)
___ Botox (Location& When_____)
___ Herpes simplex or fever blisters (A)
___ Diabetes (A)
___ Light sensitive Epilepsy (A)
___ Scars that turn white or brown (A)
___ Dark spots after pregnancy, skin injury (A)
___ HIV (A)
___ Hepatitis (A)
___ Waxing/Plucking/Electrolysis within last four weeks (HR)
___ Hirsutism (HR)
___ Transplant Anti-Rejection Drugs (HR)
___ Chemical Peels, Dermabrasion, Laser Resurfacing or Face Lift (A)
___ Tattoos/permanent make-up
___ Polycystic ovarian disease (PCOD)
___ Implants (Location:_____)
___ Collagen injection (Location:_____)

Please list any medications or over the counter & herbal supplements that you are currently taking:_____

Patient Signature Date

_____ _____

DermaTouch RN
LASER and Skin Care Clinic
13519 Hargrave Rd.
Houston, TX 77070
281-895-9090

Financial Policies

1. **Cancellations are required at least 24 hours prior to the scheduled appointment.** Failure to cancel or NO SHOW for a scheduled appointment will result in a $50.00 charge. We do text, email, and call reminders for your convenience. **Upon booking an evening or Saturday appointment, we may require a $50.00 fee. This fee will be applied to your appointment. We hope the ability to book an evening or Saturday appointment makes your treatment more convenient. Please understand that we have scheduled your nurse based on your appointment.**

2. We do not over book, and make every attempt to stay on schedule. However, in some rare instances, there may be a wait. We also understand it can be confusing to get here your very first time, but please allow yourself ample time to get here and fill out consents. **If a client is 10 minutes late, we will make an attempt to treat; this will be up to treating nurse's schedule and discretion.**

3. Photographs will be taken prior to each treatment and are the sole property of DermaTouch RN. Photos or copies of photographs are not available to be transferred with requests to release medical records.

4. Your privacy is of the utmost importance to DermaTouch RN. We make every effort to comply with all HIPPA rules.

5. We **no longer take checks from clients, and we do not take American Express**. I understand **all Sales are final**, and **no refunds are available**.

6. I understand that if I have a complimentary treatment scheduled, and I no show to my appt, or don't reschedule within 48 hours, I will lose that treatment.

7. **Please understand that because we have lasers in our facility, under no circumstance should there be a child in our facility.**

SORRY, NO EXCEPTIONS WILL BE MADE TO THIS POLICY.

PATIENT
SIGNATURE _____ DATE _____