

Date: _____ Birth Date: _____ ID# _____
 Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Employer _____ Occupation: _____
 Home Ph.: _____ Cell: _____ Work: _____
 E-mail address _____
 May we call to confirm appointments? No Yes
 Referred by: Person Yellow Pages Physician TV Radio Newspaper Other _____

Medical History

Circle Yes or No

Accutane	No	Yes
Retin-A	No	Yes
Aspirin	No	Yes
Heart Condition	No	Yes
Acne	No	Yes
Hemophilia	No	Yes
Canker Sores	No	Yes
Hepatitis	No	Yes
Carcinoma	No	Yes
HIV/AIDS	No	Yes
High Blood Pressure	No	Yes
Cold Sores	No	Yes
Keloid Scars	No	Yes
Contact Lenses	No	Yes
Metal Pins in Body	No	Yes
Dermatitis/Eczema	No	Yes
Mitral Valve Prolapse	No	Yes
Diabetes	No	Yes
Moles	No	Yes
Genital Herpes	No	Yes
Pacemaker	No	Yes
Latex Allergies	No	Yes
Botox Injections	No	Yes
Psoriasis	No	Yes
Hearing Aid	No	Yes
Tuberculosis	No	Yes
Lip Augmentation	No	Yes
Gold Therapy	No	Yes
Lupus	No	Yes
Muscle Disease	No	Yes

Desired Treatments Areas

Circle which applies:

Face: Brow/Mid//Lower	Ears	Lip: Upper/Lower
Abdomen	Eyebrows	Legs
Arms: Fore/Under	Feet: Toes	Neck: Front/Back
Back	Nose	Private Areas
Bikini Line	Hairline	Thighs
Breast: Chest	Hands/Fingers	
Chin		

Preliminary Protocol for Laser Patients

Circle which applies:

Previous Treatments:	Electrology	Electronic Tweezers
	Laser	None
	Shaving	Tweezing
	Depilatories	Waxing
Existing Skin Condition:	Scarring	Pigmentation
	Acne	Telangiectasia
	Rash	(broken blood vessels)
	Other: _____	

Which of the following best describes your skin type?

(please circle one skin type number)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Brown, moderately pigmented
- VI Black

Female Client Medical Information

In Menopause	No	Yes
Post Menopause	No	Yes
PCOS	No	Yes
Pregnant	No	Yes
Birth Control Pills	No	Yes
Hormone Pills	No	Yes
Endocrine Problem	No	Yes
Regular Periods	No	Yes
Hormonal Imbalance	No	Yes

How do you heal? Very Good Slow Healer
 Fairly Good Medical Control

Taking any type of drugs? Antibiotic Prescrip. Medications
 Photosensitive Med.

List all Medications (inc OTC/Herbal): _____

I certify the above information is correct.

I am aware that I am financially responsible for any and all procedures performed today. I understand that procedure results may vary with no guaranteed outcome.

Signature: _____ **Date:** _____ **Emergency Contact** _____

**A Medi Day Spa, Inc.
& Plastic Surgery
www.amedidayspa.com**

**700 Montgomery Hwy. Suite 230
Vestavia Hills, AL 35216
(205)824-6334**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

I _____, have received a copy of A Medi Day Spa, Inc.
Artemus Cox, M.D., P.C. Notice of Privacy Practices.

Signature of Patient

Date

**A Medi Day Spa, Inc.
& Plastic Surgery
www.amedidayspa.com**

**700 Montgomery Hwy. Suite 230
Vestavia Hills, AL 35216
(205)824-6334**

PATIENT PHOTO CONSENT

- Photos are to be used solely for education/medical purposes by Artemus J. Cox III, MD FACS and A Medi Day Spa, Inc. They are not to be used for advertising and/or media purposes.

Patient Initials_____

*(Initial here if you do not want anyone other than **A Medi Day Spa** and/or Dr. Cox to view your pictures)*

I hereby release, discharge and agree to save Artemus J. Cox III MD FACS and A Medi Day Spa, Inc from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composition form, that may occur or be produced in the taking of said pictures, or in any processing tending towards the completion of the finished product.

**Patient Signature
or Legal Guardian if under the age of 18**

Date

**A Medi Day Spa, Inc.
& Plastic Surgery
www.amedidayspa.com**

**700 Montgomery Hwy. Suite 230
Vestavia Hills, AL 35216
(205)824-6334**

PATIENT PHOTO RELEASE

Patient: _____

- I hereby give Artemus J. Cox III, MD FACS and A Medi Day Spa, Inc permission to copyright and/or publish, or use photographic portraits or pictures of me, or reproductions thereof in color or otherwise , made through any media for print , advertising, education , internet, television, or any other lawful purpose.

Patient Initials _____

**Patient Signature
or Legal Guardian if under the age of 18**

Date

**IPL - Photo Rejuvenation
CONSENT
Laser Hair Removal
CONSENT**

- ____ Initial 1. I certify that I have not sunbathed outside and/or in a tanning salon in the past 14 days. I understand that I must apply sun block with a minimum of 30 SPF every four hours on areas treated with IPL/Laser Hair Removal to prevent unwanted pigmented changes of the skin.
- ____ Initial 2. I Consent to and authorize **A Medi Day Spa, Inc. & Plastic Surgery** and members of their staff to perform multiple IPL-Photo Rejuvenation and/or Laser Hair Removal treatments and related pre- and post-treatment services on me.
3. The nature and purpose of the treatment have been explained to me and questions I have had regarding the treatment have been answered to my satisfaction. A darkening or lightening of the skin may occur, at times up to many months following treatment. Also noted, in some patients are superficial erosions, bruising, blistering, redness and swelling. There is a rare possibility that a scar and/or Keloid at the treatment site may develop.
4. I understand that the treatment may involve risks of complication or injury from both known and unknown causes and I freely assume these risks.
5. Alternative means of treatment and their risks have been explained to me and I understand that I have the right to refuse treatment.
6. No guarantee warranty, or assurance has been made to me as to the results that may be obtained.
7. I certify that I have read this entire IPL Photo Rejuvenation / Laser Hair Removal Consent and that I understand and agree to the information provided in this form. I certify that I am a competent adult of at least 18; I understand that the consent of my parent/legal guardian will also be required before treatment if under the age of 18. This IPL/Laser Consent is freely and voluntarily executed. I agree that any pictures taken of my treatment site may be used for publication or teaching purposes, however, my name will not be disclosed and complete confidentiality will be maintained.
- ____ Initial 8. I understand that multiple treatments of IPL Photo Rejuvenation / Laser Hair Therapy are necessary to achieve desired results. I also understand that it does not always provide desired results.
9. I agree to adhere to all safety precautions and regulations during the laser treatments.
10. List all medications/products (Topical and Oral) you are currently using which may cause the skin to be sensitive.
11. I understand that many follicles do not produce hair but can be activated by hormonal changes (puberty, pregnancy, aging, etc.) or by other chemical or medical conditions. That is why even after permanent hair removal it is possible for new hairs to grow.

Oral _____

Topical _____

Patient _____

Date _____

Laser Clinician _____
A Medi Day Spa, Inc.
& Plastic Surgery
www.amedidayspa.com

Physician _____
700 Montgomery Hwy. Suite 230
Vestavia Hills, AL 35216
(205)824-6334

VITALIZE CHEMICAL PEEL™

INFORMATION & INFORMED CONSENT

Patients with active cold sores or warts, wounded, sunburn, excessively sensitive skin, dermatitis or inflammatory rosacea in the area to be treated should be excluded from the Vitalize Peel™ because the procedure could potentially precipitate a flare up or spreading. Inform the esthetician if you have any history of herpes simplex (cold sores).

Patients with a history of allergies, rashes, or other skin reactions may be sensitive to treatment. Vitalize Peel™ should not be performed on patients with an allergy to salicylates (i.e. aspirin).

This peel is not recommended if you have taken Accutane with the past year, or received chemotherapy or radiation therapy.

This procedure should not be administered to pregnant or breastfeeding (lactating) women.

ONE WEEK BEFORE YOUR VITALIZE PEEL™

Avoid the following procedure for one week prior to your peel:

- 1). Electrolysis
- 2). Waxing
- 3). Depilatory Creams
- 4). Laser Hair Removal

TWO TO THREE DAYS BEFORE YOUR VITALIZE PEEL™

1. Stop using Retin-A, Renova, Differin, (Adapalene 0.1%), or any products containing Retinol, AHA or BHA, Benzoyl Peroxide.
2. Do not exfoliate.

AFTER YOUR VITALIZE CHEMICAL PEEL™

1. Immediately after the peel your skin will be slight yellow. This is temporary and will fade in 1 to 2 hours.
2. Patients with hypersensitivity to the sun should take extra precautions to guard against exposure immediately following the procedure. They should be more sensitive following the treatment.
3. Your skin may be more red than usual for 2 to 3 days. Please avoid strenuous exercise during this time.
4. Approximately 48 hours after the treatment, your skin will start to peel. This peeling will generally last 2 to 3 days. **DO NOT PICK OR PULL THE SKIN**
5. When washing your face, do not scrub. Use a gentle cleanser such as Obagi Gentle Cleanser or Kinerase Gentle Cleanser.
6. Apply light moisturizer such as Kinerase Lotion or Obagi C Day Lotion SPF 12.
7. Use a sunscreen with an SPF of at least 20, such as Obagi Healthy Skin 35 or Jan Marini Antioxidant SPF 30.
8. Do not have any other facial treatment for at least one week after your peel.
9. You may resume the regular use of Retin-A, alpha-hydroxy acid (AHA) products or bleaching creams ONLY after the peeling process is complete.

Call the spa immediately if you have any unexpected problems after the procedure. (205)824-6334

I understand that the chemical is not an exact science and the degree of improvement is variable.

I understand that occasionally there is no improvement and another form of treatment may be required.

By my signature below, I acknowledge that I read "Vitalize Chemical Peel™ Information and Informed Consent" and understand that I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. I have been adequately informed of the risks and benefits of this treatment and wish to proceed with the Vitalize Chemical Peel™.

Patient Signature

Print Name

Date