KIMIKO

John V. Tedesco, D.O., FACOS, FAACS & Chera Kimiko - Owners

PATIENT INFORMATION

First Name: Patient Name _____ MI: ____ Last Name: _____

Sex: ☐Female ☐Male Date of Birth: _____ Age: _____

Street Address: _____

City, State, Zip: _____

Cell Phone: _____ Home Phone: _____ Email Address: _____

Emergency Contact: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Family Physician: _____ Phone Number: _____

Cardiologist: _____ Phone Number: _____

Preferred Pharmacy & Phone Number and address: _____

I consent to this email address being added to the Kimiko email newsletter, where I will get information on specials and promotions. ☐ Yes ☐ No

Occupation: _____

Main area(s) of Concern: _____

_____

HEALTH HISTORY

Do you have any allergies to food, drugs, or latex? If yes, ***please list the allergy and reactions***.

_____

_____

Have you ever been diagnosed with a medical condition? If yes, please list the diagnosis and date diagnosed?

_____

_____

List surgical history with dates: _____

Please list all medications and supplements below: (Advil, Tylenol, Fish Oil, Herbal, Nasal Spray, OTC Allergy Meds,)
☐ None

Name	Dosage	Frequency	Medical Condition

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Actinic (solar) keratosis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis/gout	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Autoimmune disorder (List below) _____	☐ Yes	☐ No
Bacterial of Fungal Infections (active) List below _____	☐ Yes	☐ No
Blurred or Double Vision	☐ Yes	☐ No
Cancer or history of Cancer (List below) _____	☐ Yes	☐ No
Collagen Vascular Disease	☐ Yes	☐ No
Chemotherapy (currently)	☐ Yes	☐ No
Cold Sensitivity	☐ Yes	☐ No
COVID Vaccine Dates administered: _____	☐ Yes	☐ No
Cystic Acne	☐ Yes	☐ No
Dandruff	☐ Yes	☐ No
Dermatitis	☐ Yes	☐ No
Delayed Wound Healing	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Endocrine/Hormonal Issues	☐ Yes	☐ No
Headache/Migraines	☐ Yes	☐ No
Heart Conditions	☐ Yes	☐ No
Hematologic Bleeding Disorders	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Hereditary defects	☐ Yes	☐ No
Bleeding tendency	☐ Yes	☐ No
Hair Lice (current)	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No
Hernia	☐ Yes	☐ No
Herpes Simplex Virus 1 (cold sores) ☐ Herpes Simplex Virus 2 (genital) ☐	☐ Yes	☐ No
HIV	☐ Yes	☐ No
Hypercoagulable States	☐ Yes	☐ No
Hyperpigmentation/ Melasma	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No

Keloid (Raised) Scarring	☐ Yes	☐ No
Intramuscular Gold Therapy	☐ Yes	☐ No
Lou Gehrig's Disease	☐ Yes	☐ No
Lung Function Decreased Explain: _____	☐ Yes	☐ No
Metal Implants (list below) _____	☐ Yes	☐ No
Moles, Warts (raised) on the face, neck, or chest	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Myasthenia Gravis	☐ Yes	☐ No
Neuropathic Disorders (List below)	☐ Yes	☐ No
Open Skin Lesions, Wounds, or Sores (currently)	☐ Yes	☐ No
Pacemaker or Defibrillator	☐ Yes	☐ No
Permanent Dermal Fillers	☐ Yes	☐ No
Perino or Chilblains	☐ Yes	☐ No
Photosensitivity (extreme sensitivity to sunlight)	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No
Pulmonary emboli	☐ Yes	☐ No
Radiation to the chest	☐ Yes	☐ No
Raynaud's Disease	☐ Yes	☐ No
Recent Surgery (within the last 6 weeks)	☐ Yes	☐ No
Rosacea	☐ Yes	☐ No
Seizure Disorder	☐ Yes	☐ No
Scleroderma	☐ Yes	☐ No
Skin Cancer (history of or active)	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Sunburn (currently)	☐ Yes	☐ No
Tanning Products or Tanning Beds	☐ Yes	☐ No
Tattoos or Permanent Makeup	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Thrombophlebitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Voice Disorder/ Hoarseness	☐ Yes	☐ No
Waxing (past two weeks) Location: _____	☐ Yes	☐ No
Colitis	☐ Yes	☐ No

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FAMILY MEDICAL HISTORY

Cancer: ☐ Yes ☐ No Diabetes: ☐ Yes ☐ No Stroke: ☐ Yes ☐ No
Type: _____ heart disease: ☐ Yes ☐ No Psoriasis: ☐ Yes ☐ No
Heart Attack: ☐ Yes ☐ No Mother Father What age: _____
Other: _____

SOCIAL HISTORY

Do you smoke?	☐ Yes	☐ No	If yes, how many packs per day? _____
Did you ever smoke?	☐ Yes	☐ No	If yes, when did you quit? _____
Do you vape?	☐ Yes	☐ No	If yes, how much a day? _____
Did you ever vape?	☐ Yes	☐ No	If yes, when did you quit? _____
Do you smoke pot?	☐ Yes	☐ No	If yes, how much per day? _____
Did you ever smoke pot?	☐ Yes	☐ No	If yes, when did you quit? _____
Do you drink alcohol?	☐ Yes	☐ No	If yes, how much per day? _____
Did you ever drink alcohol?	☐ Yes	☐ No	If yes, when did you quit? _____
Are you pregnant?	☐ Yes	☐ No	If yes, how many drinks per day? _____
Are you trying to get pregnant?	☐ Yes	☐ No	
Are you lactating?	☐ Yes	☐ No	

AESTHETICS & SKINCARE HISTORY

Tell us about your current skin care products/regimen: _____
_____

- Do you currently use depilatories or wax? ☐ Yes ☐ No
  (Discontinue use five days pre-and post-treatment.)
- Have you had a chemical peel or any type of procedure with a medical device ☐ Yes ☐ No
  Within the last 14 days?
  What type? _____
- Have you ever had Botox or other dermal filler injections? ☐ Yes ☐ No
  Last injection? _____
- Have you recently had laser resurfacing or facial surgery ☐ Yes ☐ No
  Describe: _____
  When? _____
- Are you currently taking any medication, topical or otherwise? ☐ Yes ☐ No
  (Tretinoin / Retin-A / Renova / Differin / Tazorac / Avage /EpiDuo / Ziana)
  Which one(s)? _____
  For how long? _____
  What strength? _____
- Have you ever undergone Accutane therapy (isotretinoin)? ☐ Yes ☐ No
- Have you ever used any other skincare products that caused a negative reaction? ☐ Yes ☐ No

  Describe: _____

  List history of any other aesthetic treatments: _____

Patient Signature: _____ **Date:** _____

Provider Reviewed: _____ Date: _____

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COSMETIC INTEREST QUESTIONAIRRE

X	Interest	Notes
	Dry or Oily Skin	
	Tired Looking Skin or Uneven Skin Tone or Texture	
	Brown Spots. Sun Damage Or "Hyperpigmentation"	
	Clogged or Large Pores	
	Acne: Face or Back	
	Rosacea, Facial Redness, Facial Veins	
	Fine or Deep Wrinkles- list area of concern	
	Lines Above Lips or Around Mouth	
	Facial Volume Loss/ Sagging	
	Neck: Wrinkles, Loose Skin, or chin/jowl Fat	
	Under Eye Hallowing or Wrinkles	
	Lip Lines or Thin Lips or Lip Augmentation	
	Jawline Definition	
	Chin: Wrinkled or Needs Volume	
	Aging Hands	
	Unwanted Facial or Body Hair	
	Scars (Acne or Surgical)	
	Skin Tightening (Face or Body)	
	Excessive Sweating	
	Body Contouring, Fat Reduction, or Cellulite	
	Leg Veins	
	Length or Fullness of Eyelashes, Color of eyebrows	
	Prevention or Maintenance for my skin	
	Interested in Skincare Products	

Patient Signature: _____ **Date:** _____

Provider Signature:_____ Date: _____

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ACKNOWLEDGEMENT OF PRACTICE POLICIES

I understand that I will be required to pay a $50 consultation fee that can be applied toward services purchased within 7 days of consultation. In addition, prior to any treatment being performed, I will be required to sign an informed consent. Any treatment performed at Kimiko Medical Aesthetics is cosmetic in nature and the decision to proceed is based on my desire to do so**:_____(Please Initial)**

PAYMENT POLICY

I understand that my treatments at Kimiko require payment upon services rendered and the prices and fee structure for treatment have been explained to me. The quoted price for treatment is the price for each individual treatment session unless otherwise specified in writing by Kimiko. For cosmetic medical procedures, I understand that the services often require more than one session to achieve the best outcome, and I have the option of purchasing a series/package of treatment sessions at the quoted package price. There are no refunds on treatments paid in advance, however, any money paid can be used toward another treatment. Any refunds will be determined on a case-by-case basis after appropriate management approval and or sufficient reason. I further understand that the services offered by Kimiko are elective in nature and are not covered by health insurance. I agree to pay for the treatment according to the payment plan discussed. We accept payment in the form of cash, check, major credit cards, or Care Credit. _____ **(Please Initial)**

RESCHEDULING/CANCELLATION AND NO-SHOW POLICY

We understand that sometimes it is necessary to reschedule or cancel your appointment. If you need to reschedule or cancel, please contact us 24 hours in advance of your scheduled time. Call or text our office at 918-394-2796 or email info@kimikotulsa.com.

All rescheduling/cancellations within the required 24 hours' notice; will result in a $50 fee that will be charged to your card on file.

A No Show is considered a failure to cancel or fail to show for a scheduled appointment; a $50 fee will be charged to your card on file. This courtesy enables us to compensate our employees for their time and maintains a higher availability of our time for you as well as others. By scheduling an appointment, you are agreeing to our Rescheduling/Cancellation and No-Show policy. Patients arriving more than 15 minutes late may result in a shortened appointment or a cancellation if there is not enough time to complete the procedure. If your appointment is rescheduled or canceled due to late arrival you will be charged the $50 cancellation fee. We regret any inconvenience this may cause. _____**(Please Initial)**

RETURN POLICY

All sales of skincare and makeup products are final. Unopened products may be returned with a receipt for a credit within 7 days. All treatment services are non-refundable. Management may, at its discretion, allow you to apply the remaining unused balance towards other services. _____**(Please Initial)**

DISCLAIMER

I understand that all medical cosmetic treatments are provided exclusively by Kimiko Medical Aesthetics. I will not hold Kimiko, its owners, or its employees responsible for the results I experience. I realize that results may vary. I further understand that Kimiko cannot prescribe an exact number of treatments to satisfy each individual's opinion and that the number of treatments I complete will be at my own discretion. _____**(Please Initial)**

I understand that even with the best laser and the highest trained and board-certified medical providers, there is a percent of patients that are non-responders and will not have a desired response/outcome to treatments. _____ **(Please Initial)**

CONSENT TO PHOTOGRAPH (check one or both)

☐ I consent to be photographed during the course of my treatment with Kimiko. I understand that the purpose of such photographs is to track the progress of my treatment(s). I understand that my photographs are part of my medical records and therefore, are the property of Kimiko.

☐ I consent to the use of my photographs, at the discretion of Kimiko for marketing (social media or Kimiko website), research, educational, and/or scientific purposes. **I understand that every attempt will be made to protect my identity and my name will not be disclosed. If we would like to use a picture that clearly shows your face, we will ask your permission first.**

PRIVACY

I have read and fully understand all the terms of this Acknowledgement of Practice Policies form, all my questions have been answered to my satisfaction and I agree to the terms of this consent.

Print Patient name: _____

Signature:_____ **Date:** _____

KIMIKO

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as a patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies: **(Please Initial)**

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information that is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information. _____ **(Please Initial)**

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative. _____ **(Please Initial)**

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA. _____ **(Please Initial)**

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in the normal performance of their duties. _____ **(Please Initial)**

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor. _____ **(Please Initial)**

6. Your confidential information will not be used for the purposes of marketing or advertising products, goods, or services. _____ **(Please Initial)**

7. We agree to provide patients with access to their records in accordance with state and federal laws. _____ **(Please Initial)**

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient. _____ **(Please Initial)**

9. You have the right to request restrictions in the use of your protected health information and to request changes in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
   I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward. _____ **(Please Initial)**

Print Patient name: _____

Signature:_____ **Date:** _____