Family Doctors
OF GREEN VALLEY
Where your family comes first.

PATIENT INTAKE FORM

ZERONA®

PATIENT INFORMATION

Name:		
Address:		
City:	State:	Zip:
Email:		May we email you promotions or announcements? ❑ Yes ❑ No
Home Phone:	Work Phone:	Cell Phone•

Preferred method of contact for appointment reminders and/or messages: ❑ Email ❑ Home ❑ Work ❑ Cell

Referred by (How did you hear about us?):

Today's aesthetic interests and concerns:

❑ Body Contouring ❑ Fat Reduction ❑ Cellulite ❑ Skin Tightening

Future aesthetic interests and concerns:

❑ Body Contouring ❑ Fat Reduction ❑ Cellulite ❑ Skin Tightening

MEDICAL HISTORY

Allergies:

❑ Bacterial Proteins ❑ Bovine

History of past or current medical conditions: (Please check all that apply.)

Abdominal Surgery (Tummy Tuck)
❑ Abnormal Bruising/Bleeding
❑ Abnormal Hair Growth
❑ Abnormal Periods
❑ Active Collagen or Vascular Disease
❑ Anaphylaxis
❑ Autoimmune disorders (Lupus, etc.)
Cancer, including Skin Cancer
❑ Circulation Problems
❑ Cold Sores
❑ Chronic Skin Disorders
❑ Diabetes
❑ Heart Problems
❑ Hepatitis C/D Positive
❑ Herpes Simplex Virus
❑ High or Low Blood Pressure
❑ HIV/AIDs
❑ Lactating (Breast Feeding)
❑ Liposuction (check area below)
❑ Abdomen ❑ Flanks
❑ Thighs ❑ Buttocks
❑ Hips ❑ Other
❑ Lypomas
❑ Lypodema
❑ Multi-Systemic Diseases (Diabetes, Hypertension, Coronary Artery Disease, Renal Insufficiency, etc.)
❑ Metabolic Disorders
❑ Organ Transplant
❑ Pacemaker or Automatic
❑ Defibrillator/AICD
❑ Phlebitis and blood clotting
❑ Polycystic Ovary Syndrome
❑ Pregnancy
❑ Slow Healing of Cuts/Bruises
❑ Thickened Scars

Please describe any "checked" answers above:

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PATIENT INTAKE FORM (continued)

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MEDICAL HISTORY (continued)

Aside from answers marked above, have you had any other serious illnesses? If yes, what and when? Please circle.

Yes No

Have you ever had any surgery? If yes, what and when? Please circle.

Yes No

Have you ever had any aesthetic procedures such as laser therapy, peels, etc.? If yes, what and when? Please circle.

Yes No

Have you ever had any injectables such as Botox® Cosmetic, Restylane®, etc.? If yes, what and when? Please circle.

Yes No

CURRENT MEDICATIONS/HERBAL SUPPLEMENTS/VITAMINS: (Please circle all that apply.)

Accutane (within 6 months) Aspirin Immunosuppressant Medications Anti-inflammatories

SOCIAL HISTORY

Alcohol consumption? If yes, how often? Please circle.

Yes No

Cigarette smoker? If yes, how many per day? Please circle.

Yes No

Recreational Drug Use? If yes, how often? Please circle.

Yes No

ACKNOWLEDGEMENT

I confirm that the answers to the questionnaire are true and correct, to the best of my knowledge.

I also confirm _____ and staff explained the treatment(s) and answered my questions.

Patient Name:_____

Signature:_____

Date: _____

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INFORMED CONSENT FOR ZERONA

ZERONA®

You have elected to be treated with ZERONA®, a low level laser manufactured by Erchonia Medical®. This treatment involves the application of a 635nm low intensity laser for the disruption of adipocyte cells within the fat layer for the release of fat and lipids from these cells for non-invasive aesthetic use.

ZERONA® has been cleared by the FDA as both safe and effective for the reduction of circumference of the hips, waist, thighs and arms. Though safe and non-invasive, any medical or cosmetic procedure carries risks, complications and varied results as to its effectiveness. The purpose of this document is to make you aware of the nature of this procedure and its risks in advance so that you can decide whether to go forward with this procedure.

Contraindications for this procedure include:

- Accutane (Isotretinoin) use within the last six months.
- Active infection or impaired immune system (i.e., HIV / AIDS).
- Actively trying to become pregnant, pregnancy or breastfeeding.
- Anticoagulant use.
- Autoimmune conditions (i.e., Crohn's Disease, Vitiligo, Lupus (SLE), Rheumatoid Arthritis, etc.). A letter of clearance from your physician is required.
- Cancer: Current diagnosis of cancer anywhere in the body or pre-malignant moles in the treatment area.
- Children under age 13.
- Lymphatic impairment. Fat mobilization may be hindered which may affect outcomes.
- Open wound or any active condition such as eczema, rashes, sores or inflamed skin in the treatment area
- Pacemaker, cardioverters/ internal defibrillator or any other implantable electrical device.
- Severe chronic medical conditions (i.e., congestive heart failure, liver failure, renal failure, lymphatic disease, etc.). A letter of clearance from your physician is required.

Patient Signature: _____

Date: _____

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FINANCIAL POLICY AND ACKNOWLEDGEMENT ZERONA

ZERONA™ technology is complemented by VIEX Fat Burner™ and Energy Boost, supplements strategically designed to enhance results by assisting your body in removing and metabolizing the ZERONA™ released fat. Accordingly, if no contraindications are present, VIEX Fat Burner™ and Energy boost is recommended.

There are a few risks associated with low-level laser therapy. The only known risk with the use of this device is the long-term exposure to laser light which may cause damage to your eyes if unprotected. You will be provided with protective eyewear at the beginning of your procedure and you must wear them throughout your treatment to avoid the risk.

We have developed this policy to detail your financial requirements to help you better understand your responsibilities.

The payment of fees for services is the direct responsibility of the patient and due and payable at time of service. Individual results vary due to genetic and nutritional components therefore no guarantee is made on the amount of inches or how much fat will be lost during treatment. No refunds or exchanges

I understand that this is an elective non-invasive, cosmetic procedure and that a series of treatments is recommended and required to achieve desired results. I understand and acknowledge that no guarantees have been made to me concerning the results of this procedure. Failure to follow the Patient responsibilities may result in failure to achieve the desired results. Complications or a poor outcome may manifest weeks, months or even years after Zerona™ laser treatment. In addition, I am not now and do not expect to become pregnant during the course of treatments. Although there is no known detriment to low level laser treatment during pregnancy, potential unknown risks may exist.

Zerona™ low level laser and its risks, benefits, and alternatives, including not doing the procedure in addition to my Patient Responsibilities have been explained to me and my questions have been answered. I therefore consent to having Zerona ™ low level laser treatments.

<u>I understand and acknowledge Zerona™ are at my own risk and no guarantees, written or implied were made.</u>

Patient Name: _____ Account # _____

Patient Signature: _____ Date: _____