PURPLE PLUM AESTHETICS
NEW PATIENT INFORMATION

Today's Date: ___/___/_____

Last Name: _____ First Name: _____DOB: ___/____/_____
Address: _____City: _____ State: _____ Zip: _____

Phone number to contact you regarding treatment, to leave a message and appointment reminders:
Cell Phone: (____) _____ Email (for reminders and monthly specials): _____
How did you hear about us? _____ May we thank them for referring you? Yes/No
Emergency Contact: _____ Phone: (____)_____
Primary Care Physician: _____ Phone: (____)_____

Please answer YES or NO to the following:

YES NO Are you using any prescribed medications? List: _____
YES NO Are you using any allergy, cold or sleeping medications? List: _____
YES NO Are you using any herbal supplements? List: _____
YES NO Do you take anti-coagulant (blood thinning) medication? List: _____
YES NO Are you allergic to any cosmetic ingredients, medications, topical anesthetics, lidocaine, latex, chlorhexidine, gram-positive bacterial proteins, phenylephrine bee stings or foods?
List: _____
YES NO Do you have a history of multiple severe allergies or anaphylaxis?
YES NO Are you pregnant, trying to become pregnant or breastfeeding? _____
YES NO Do you smoke? How much? _____ How long? _____
YES NO Do you spend a lot of time outdoors or use a tanning bed often?
YES NO Do you have any tattoos or permanent makeup? Where? _____

Please check any chronic skin disorders, or check ☐ NONE

☐ Cold sores	☐ Fever or sun blisters	☐ Dermatitis	☐ Skin infections
☐ Psoriasis	☐ Eczema	☐ Rosacea	☐ Herpes Simplex/blisters
☐ Excessive scarring	☐ Keloid scarring	☐ Cystic acne	☐ Pigmentation disorder

☐ Other: _____

Please check any health problems, past or present, or check ☐ NONE

☐ Seizures	☐ Hormonal problems	☐ Neuro-Muscular disease or disorder
☐ High blood pressure	☐ Cardiovascular disease	☐ Hepatitis/HIV/AIDS
☐ Asthma or pulmonary issues	☐ Emphysema	☐ Difficulty breathing or swallowing
☐ Vasovagal syncope	☐ Liver disease	☐ Diabetes
☐ PCOS	☐ Kidney disease	☐ Collagen disorder
☐ Thyroid disease	☐ Sarcoidosis	☐ Autoimmune disease
☐ Immunosuppression	☐ Blood disease	☐ Clotting or bleeding disorder
☐ Eye or vision problems		

☐ Cancer/Skin Cancer - Type:_____ Location: _____ When treated: _____
☐ Other: _____

What is your skin type: ☐ Dry ☐ Combination ☐ Normal ☐ Oily

Please tell us your main concerns that brought you to our office today: _____

Have you ever had any of the following injectables, fillers or implants? or check ☐ NONE

☐ Botox, Dysport, Xeomin, Jeuveau or other botulinum toxin?

What? _____When? _____ What areas? _____

☐ Juvéderm, Restylane, Sculptra or other dermal filler?

What? _____When? _____ What areas? _____

Have you ever undergone any of the following skin treatments? or check ☐ NONE

☐ Chemical peel ☐ Microneedling ☐ Skin resurfacing or fractional laser

☐ Facial surgery ☐ Lasers ☐ Accutane ☐ Cosmetic surgery

☐ Other: _____

What? _____When? _____ What areas? _____

Which conditions concern you the most:

☐ Wrinkles	☐ Uneven skin tone	☐ Brown spots, sun spots, freckles
☐ Sun Damage	☐ Upper lip lines	☐ Visible veins or blood vessels
☐ Enlarged pores	☐ Scarring	☐ Excessive oiliness
☐ Melasma	☐ Blackheads/Whiteheads	☐ Dry patches
☐ Acne/Pimples	☐ Hard bumps under skin	☐ White spots (Hypopigmentation)
☐ Facial redness	☐ Rosacea	☐ Sparse or short eyelashes
☐ Unwanted hair	☐ Other: _____	

Please list the products you currently use and list the brand names of the products:

☐ Cleanser _____	☐ Toner _____
☐ Moisturizer _____	☐ Sunscreen/SPF _____
☐ Eye cream _____	☐ Vitamin C product _____
☐ Retinol/Retin-A_____	☐ Skin lightening product _____
☐ AHA/BHA product _____	☐ Lash product _____
☐ Acne product _____	☐ Other _____

Are you using any prescription topical products or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation? List: _____

Are you currently removing hair by any of the following methods?

☐ Waxing ☐ Tweezing ☐ **"**Nair" type products

☐ Electrolysis ☐ Laser hair removal: When? _____ What areas? _____

REQUIRED FOR SKIN ANALYSIS & TREATMENT
Your Ethnicity:
Mother's Ethnicity: Father's Ethnicity:
Are you tan? _____ Do you tan artificially?_____ Tanning Bed? _____ Spray-on Tan? _____
When was the last time you had a significant amount of sun exposure?

HIPAA Acknowledgement : I have been informed by Purple Plum Aesthetics of the HIPAA law regarding privacy practices and procedures and have been offered a copy of its HIPAA policies.

I certify that the above information is correct to the best of my knowledge.

_____ _____ _____

Patient Signature *Print Name* *Date*

Purple Plum Dentistry/Aesthetics Notes: _____

Medical History Form

Name: _____ Address: _____

Home Phone: _____ Work: _____ Cell: _____ Age: ___ Referred by: _____

Have you ever had the following?

- ☐ Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre-cancerous lesions such as multiple dysplastic nevi.
- ☐ Any active infection.
- ☐ Diseases: Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria.
- ☐ Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications.
- ☐ History of bleeding, coagulopathies, or use of anticoagulants
- ☐ History of keloid scarring.
- ☐ Very Dry Skin
- ☐ Exposure to sun or artificial tanning during the 3–4 weeks prior to treatment.
- ☐ Are you pregnant? ☐ Yes ☐ No
- ☐ What medications are you taking (including aspirin)? _____
- ☐ Daily consumption of alcohol: _____
- ☐ Allergies: _____
- ☐ Are you taking any herbal preparations? (St. John's Wort, etc.) _____
- ☐ If yes, list: _____
- ☐ Do you wear contact lenses? ☐ Yes ☐ No

Skin type (when exposed to the sun without protection for about 1 hour)

☐ Always burns, never tans ☐ always burns, sometimes tans

☐ Sometimes burns, sometimes tans ☐ always tans

☐ Hispanic ☐ Asian ☐ Mediterranean ☐ Middle Eastern ☐ Black

When is the last time you were exposed to sun (including tanning booth)? _____

Do you use chemical sun tanning lotions? _____ Are you planning a holiday in the sun? _____

Reason for visit (area to be treated): _____

Prior treatment (if any): _____

What is your skin care routine at home: _____

_____

Consent Form

I, _____, authorize PURPLE PLUM DENTISTRY,
To perform an Opus Plasma treatment on the Following area(s) of my body:
_____
The Opus treatment uses high-frequency unipolar radio frequency to create controlled zones of coagulation to chosen depths into the dermis that stimulate neocollagenesis (new collagen). The Opus treatment addresses texture and tone as well as other effects of photo aging skin.

Review of facts about Opus Plasma

- When in proximity of the skin, the RF-charged pins react to atmospheric pressure in the air, creating plasma that in turn, creates the micro thermal columns of wounded tissue that stimulates new collagen.
- Opus plasma treatment procedures may produce scanning patterns visible on the skin. This event usually fades while in the healing phase.
- The sensation, while being treated, may feel like pin pricks, bursts of heat or like sunburn. The type of topical and or injected anesthetics is at the discretion of the practitioner. There are known severe allergic reactions to ingredients in topical anesthetics. Patients with known allergies to anesthetics will list them here:
  _____

Pre-treatment considerations

- If you have previously suffered from facial cold sores, there is a risk that this treatment could contribute to a recurrence.
- No one who has taken the medication Accutane or its generic forms within the last year may have this procedure.
- Skin care or treatment programs may be used before and after laser skin treatments to enhance the results.

Treatment considerations

- The procedure necessitates a post treatment care regime that must be followed.
- Redness and flaking of skin is associated with this procedure and may last from 5-7 days depending on the depth and concentration (percentage) of the treatment performed. You may notice a sandpaper texture and bronzing of the skin as

the microscopic columns begin to heal. This is treated tissue working its way out as new skin is regenerated. Keeping the area moist with a light application of a Cerave or CBD+ barrier restoring cream will aid in the healing process.

Common side effects and risks

- Edema (swelling) of the skin may occur and can be minimized by keeping the area upright.
- Urticaria (itching) often occurs as the old skin is shed and the new skin is being formed.
- If any of the above symptoms intensify, your clinician should be notified. A cool compress placed on the area provides comfort. The treated area should be cared for delicately. Limited activity may be advised, as well as no hot tub, steam, sauna, or shower use.
- Discomfort, especially a sunburn feeling, may persist for a few days.
- § PIH or post inflammatory hyper pigmentation (browning) and hypo pigmentation (lightening) have been noted with laser procedures. These conditions usually resolve within 2-6 months. Permanent color change is a rare risk. Vigilant care must be taken to avoid sun exposure (tanning beds included) before and after the treatment to reduce the risk of color change. After the skin has gone through its healing phase and is intact, sunscreen and / or sun block should be applied when sun exposure is necessary.
- Infection is not usual after treatments; however, herpes simplex virus infections around the mouth can occur following treatments. This applies to both individuals with a history of the virus or individuals with no known history. Other signs of an infection can be a fever, purulent (pus) material, severe redness, swelling in the area, and skin that is hot to the touch. Should these symptoms occur, the clinician must be notified to prescribe appropriate medical care.
- Allergic reaction is uncommon from treatment. Some persons may have a hive-like appearance in the treated area. Some persons have localized reactions to cosmetics or topical preparations. Systemic reactions are rare.

The potential risks and benefits have been explained of Opus Plasma treatment along with alternative methods. I choose to have Opus Plasma fractional treatment.

I understand that compliance with pre and post care instructions is crucial for success of Opus Plasma treatment and to prevent unnecessary side effects or complications.

I understand that there are many variable conditions which influence the long-term result of skin treatments. The practice of medicine and surgery and the subsequent use of plasma is not an exact science. Although good results are expected, there is no guarantee, expressed or implied, on the results that may be obtained.

I do____ or do not _____ consent to photographs and other audio-visual and graphic materials before, during, and after the course of my therapy to be used for medical, marketing, and education purposes. Although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos.

Disclaimer: Informed consent documents are used to communicate information about the proposed treatment of a disease or condition along with disclosure of risks and alternative forms of treatment. The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your physician

may provide you with additional or different information which is based on all the facts in your case and the state of medical knowledge. Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined based on all the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

I have read and understand all information presented to me before signing this consent form. I have been given an opportunity to have all my questions answered to my satisfaction. I understand the procedure and accept the risks.

I agree to the terms of this agreement.
Patient's Name (Printed): _____
Signature: _____ Date: _____
Witness: _____

I have been given an opportunity to ask questions about my condition, alternate forms of anesthesia [if applicable] and treatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent. By signing below, I certify that I have read and fully understand the contents of this document and that I have received and understand all the disclosures referred to herein. [I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment. I voluntarily consent and authorize that this Procedure to be performed by ***Purple Plum Dentistry/Purple Plum Aesthetics.***

X _____
Anita Kianimanesh, DMD
Owner

X _____
Patient's Signature

Patient Interest Questionnaire

Name: Age: Date: / /

Please indicate any areas of concern for you

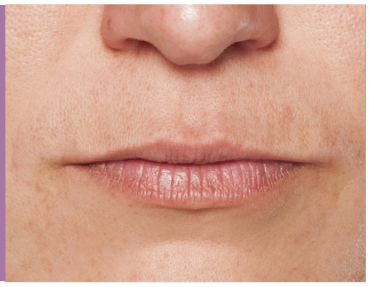
Check all that apply.

- ☐ Forehead lines

- ☐ Lip appearance and texture

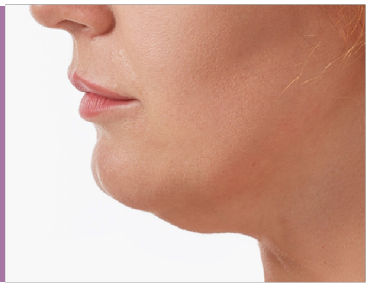
- ☐ Frown lines

- ☐ Thin lips



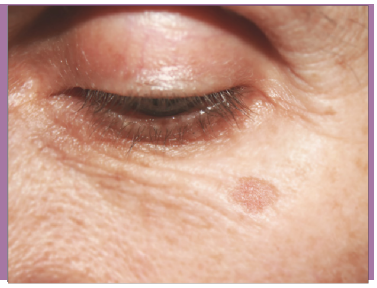
- ☐ Crow's feet lines

- ☐ Double chin

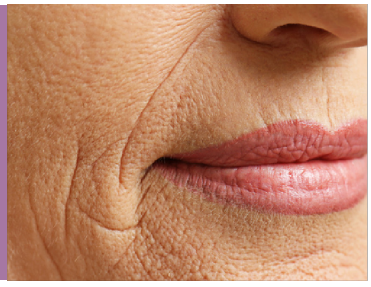


- ☐ Flattened cheeks/ sunken cheeks

- ☐ Skin appearance and texture



- ☐ Lines and wrinkles around the nose and mouth



- ☐ Any other Concerns:

Please complete questionnaire on back side.

Patient Interest Questionnaire

Share how you see yourself

I feel like I look:
Check all that apply.

- [ ] Sad
- [ ] Less lively
- [ ] Pained
- [ ] Other
- [ ] Angry
- [ ] Fearful
- [ ] Less desirable
- [ ] Tired
- [ ] Saggy
- [ ] Older than I feel

Evaluate concerns and aesthetic goals to customize each consultation

Patient name: Next appointment date: / /

Purple Plum Aesthetics
800 W Broad St Suite 207
Falls Church, VA 22046
703-998-4244

OPUS PLASMA INSTRUCTIONS

PRE-TREATMENT INSTRUCTIONS

- 6 months prior to treatment, absolutely NO Accutane
- 14 days prior, avoid all laser treatments, botox and sun exposure
- 7 days prior, stop using all topical Retinoids including Retin A
- 3 days prior: remove your facial hair (fuzz) use dermaplanning tool.
- 3-5 days prior, increase water intake to 48 to 64 oz per day, including the day after treatment. Avoid excessive alcohol.
- 3 days prior: No peels, facials, exfoliants, topical antibiotics, exfoliating masks, or hydroquinone, benzoyl peroxide acne products, alpha hydroxyl acids (AHA), or betahydroxyl acids (BHA).
- If you have history of cold sores, we will prescribe Valtrex 500mg (one pill twice daily starting 2 days prior to treatment and continuing for a total of five days. .
- Darker skin types may choose to pre-treat with hydroquinone 2 weeks prior to treatment.
- You may use Arnica Montana pills to help prevent bruising 2 days before (you can usually find them at a health food store).
- We will recommend CBD facial treatment specially for you. or you canpurchase a gentle lotionsuch as CeraVe or Cetaphil and an SPF 50 sunblock for the face.

DAY OF TREATMENT INSTRUCTIONS

- Avoid lotion, creams, makeup or deodorant in area to be treated. Arrive with clean,was hed skin without make-up
- Update Purple Plum Dentistry about any changes in skin condition, medical history, supplements, and OTC meds
- NO active cold sores, herpes simplex the area to be treated, open sores, sun burns, within the application area
- Eat a meal and hydrate at least 2 hours prior to treatment

POST-TREATMENT INSTRUCTIONS

- *For the first 24 hours:*
    - Avoid sun exposure, strenuous exercise, saunas, Jacuzzis, any heat, etc. as heat retention in the skin can last up to 24 hours.
    - Make sure to hydrate.
    - Use the Recovery Kit
- *For the next 7 days:*
    - Redness may last up to 24-48 hours.
    - When a light scabbing occurs, a wound healing product such as Aquaphor or e quivalent can be applied as needed.
    - The skin should only be gently cleansed, moisturized and applied with sunscreen please use your recovery kit or (Cetaphil, CeraVe - available at any drugstore).
    - No ACIDS! Avoid Obagi, Retin-A, other exfoliating products
- *After day 7:*
    - If indicated, make-up can be applied. Can resume normal skin routine. Continue to wear sunscreen daily
    - If adverse skin effects occur (such as excessive reddening, blistering or swelling), pleasecontact us.