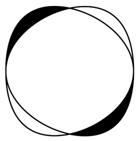

MINTSKIN
AUSTRALIA

MINTSKIN clinic
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Patient Registration Form

IPL | OPT | M22

Treatment type____

This blank filled out by staff ONLY

Name 姓名_______________________(First Name 名) ______________(Surname姓) Date of Birth生日 __________________(DD/MM/YYYY)

Gender性别___________ Email 电子邮箱____ Phone 电话号码__________________

We will send you the digital version and other updates. 我们将向您发送数字版本和其他更新信息。

Please read the following statements carefully and tick all the boxes 请仔细阅读下列描述并在所有方框内打勾

The theoretical basis of **IPL**(intense pulsed light), in the treatment of skin diseases, is the principle of selective photothermal action. The treatment of acne mainly uses photochemical action and selective photothermal action. IPL脉冲光治疗皮肤病的理论基础是选择性光热作用原理。治疗痤疮主要是利用光化学作用和选择性光热作用。

In the pigment treatment, melanocytes can be destroyed by light energy and eliminated with metabolism. In the vascular treatment, the light energy of IPL is preferentially and selectively absorbed by oxygenated hemoglobin in blood vessels, so as to weaken the red blood filaments. 治疗色素性皮肤病时，黑素细胞可被光能破坏随新陈代谢排出体外。治疗血管性疾病时，IPL的光能被血管内的氧合血红蛋白优先选择性吸收从而淡化红血丝。

Before treatment, a site testing may be carried out to help determine effective treatment settings. 在治疗前，可能对局部进行定点测试，有助于确定有效的治疗设置。

During treatment, you may feel tingling, warm and other discomfort . You will feel the light emitted by the instrument and the cold feeling of the applicator in contact with the skin. 在治疗时，脉冲光治疗过程你可能会感受到刺痛发热等不适的感觉，你会感受到仪器发出的光感，和治疗头与皮肤接触的冰凉感觉。

After treatment, there will be temporary redness, swelling, heat and pain in the treatment area, which may last for several hours.在治疗后，治疗区域会有暂时红肿热痛的感觉，此情况可能会持续几个小时。

The heat energy generated by IPL will bring the inflammation of the basal layer to the skin surface. Therefore, inflammatory acne will appear 1-2 days after treatment. The extra repair treatment within 1 week is recommended. The package recommend guide is designed for optimal results. IPL脉冲光产生的热能会将基底层的炎症带到皮肤表面，因此术后1-2天会出现炎症痘痘，建议一周内进行额外的修复护理。疗程推荐指南旨在帮助您获得更好的结果。

You may also have slight pigmentation at the treatment site, which can be eliminated within 1-2 weeks without drug intervention.您也可能在治疗部位出现出现轻微色沉，在没有药物的介入下可以在一周至两周内消除。

I know the operation process of this treatment and confirm that my skin and other health conditions are suitable for this treatment. 本人已知该项目治疗操作流程，并确认本人皮肤和其他健康状况适合操作此项目。

I know the repeated treatment by month will help to achieve a better result and results can vary by each customer. 本人已知晓该项目按月度疗程治疗更有助于呈现好的结果，效果将因人而异。

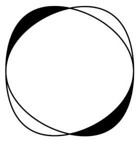
------------- If **YES**, please let us know 如果是，请让我们知道-------------

I have **NOT** take oral hormone and vitamin A drugs in the past 3 months. 本人过去3个月没有口服激素类和维生素A的药物。

I am **NOT** in a lactation period or pregnant period. 本人未处于哺乳期或者怀孕期。

I have confirmed that I have **NO** light allergy and have **NOT** eaten light sensitive food before the treatment. 本人已确认无光过敏症, 没有在治疗前食用光敏感性食物。

Signed签名 ________________________ Date 日期 _______________________ (DD/MM/YYYY) *Please Turn Over...请翻页...*



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General Health History 健康史

Have you suffered any serious illness? 您是否有任何严重病史？ ___________________________Please fill in **No** if not applicable如不适用，请填无

What operations have you had? 您做过什么手术？ _______________________________________Please fill in **No** if not applicable如不适用，请填无

Please indicate if you have a history of the following: 请说明您是否有以下历史记录：

Allergies过敏	Blood pressure血压问题	Hepatitis肝炎
Rheumatic fever风湿	Fainting昏厥	Bleeding tendency出血倾向
Blood clots, thrombosis 血块血栓	Epilepsy癫痫	Diabetes糖尿病
Heart trouble心脏疾病	Kidney disease肾病	Lung disease肺部疾病
Other其他		

*Are you at risk of developing HIV, AIDS or Hepatitis? 您是否有感染艾滋病毒、艾滋病或肝炎的风险？

YES是 NO否 (Please select one 必填单选)

*Is there anything of a confidential nature you wish to discuss with the nurse? 您是否希望与护士讨论任何保密事项？

YES是 NO否 (Please select one 必填单选)

***Allergies:** Are you allergic to any medicines, lotions or tape? Please list 请列出任何您过敏的药物、乳液或胶带：

____

***Bleeding tendency:** Are you subject to prolonged bleeding or frequent nose bleeds? 您是否会长期出血或频繁流鼻血？

YES是 NO否 (Please select one 必填单选)

Cortisone: Have you ever been given cortisone or steroid tablets or injections? Please specify when 你是否曾服用可的松或类固醇药片或注射？请说明何时

____

Medication: Please list any current medication (including herbal / alternative) 请列出任何当前药物（包括草药/替代品）

____

Repair nursing instructions after treatment 治疗后护理建议

- Avoid the use of hormone drugs, oral or coated vitamin A. 应避免使用激素类药物，口服维生素A或者涂抹式维生素A。
- Avoid prolonged sun exposure, high temperature yoga and sauna and other activities at high temperature. 应避免长时间日光暴晒，高温瑜伽和桑拿等高温活动。
- Avoid bacterial infection at the treatment site . Use physical and chemical methods to prevent UV and you need to wear at least a SPF 30 sunscreen. Pay more attention to skin moisturizing between treatments. 避免治疗部位受到细菌感染。使用物理和化学方法防晒，并使用至少SPF 30的防晒霜。在治疗后以及治疗间隔期做好肌肤保湿。
- Avoid using irritating cosmetics such as whitening, and exfoliate and peel treatments must be under the guidance of professionals. 应避免使用美白等刺激性化妆品，在专业人员指导下进行去角质和刷酸。

Signed签名 __________________________ Date 日期 ________________________ (DD/MM/YYYY) *Please Turn Over...*请翻页...

Privacy Consent Form 隐私同意书

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.我们要求您同意收集您的个人信息。请仔细阅读此信息，并在下面指示的位置签名。

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways: 本医疗机构从您处收集信息的主要目的是提供优质医疗服务。我们要求您向我们提供您的个人详细信息和完整的病史，以便我们能够正确评估、诊断、治疗您的健康护理需求，并采取积极主动的态度。这意味着我们将通过以下方式使用您提供的信息：

- Administrative purposes in running our clinics, including confirmation of appointments,take before and after photographs of you, write file notes about your skin, your treatment, medical conditions and your leisure activities. 管理我们诊所的目的，包括预约确认, 拍摄你的前后照片，记录你的皮肤、治疗、医疗状况和日常活动。‹

- Billing purposes 计费目的。

- Disclosure to others involved in your health care, including treating doctors and specialists outside our clinics. This may occur through referral to other doctors, or for medical tests, and in the reports or results returned to us following the referrals. 向参与您医疗保健的其他人披露，包括在本医疗机构之外治疗医生和专家。这可能通过转诊给其他医生或进行医学测试，以及在转诊后返回给我们的报告或结果。

- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care, teaching and research. Please let us know if you do not want your records accessed for these purposes and we will note your record accordingly. 为患者护理、教学和研究的目的，向执业机构的其他医生、医生和注册人员披露信息。如果您不希望出于这些目的访问您的记录，请告知我们，我们将相应地记录您的记录。

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.我已阅读上述信息，并理解必须收集我的信息的原因。我还知道，该机构在处理患者信息方面有隐私政策。

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.我理解，我没有义务提供要求我提供的任何信息，但如果我不这样做，可能会影响提供给我的医疗保健和治疗的质量。

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.我知道我有权访问收集到的关于我的信息，除非在某些情况下，可能会合法地拒绝访问。我知道在这种情况下我会得到解释。

I consent to the use of my non-identifying clinical photographs for educational purposes in the practice / at medical lectures / medical journals, or for marketing purposes我同意将我的非识别临床照片用于实践/医学讲座/医学期刊的教育目的，或用于营销目的。.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.我理解，如果我的信息用于上述以外的任何目的，我将获得进一步的同意。

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.本人同意本机构出于上述目的处理本人的信息，但须遵守本人通知本机构的任何访问或披露限制。

Signed签名 ________________________ Date 日期 _____________________ (DD/MM/YYYY) Witness 见证人____________________