DERMALOGIC Laser Center

PATIENT INFORMATION

Please Print

Last name: ______________________ First name: ______________________ Middle initial: ______

Date of Birth: ____________ Gender: Male Female Marital Status: M S W D

Phone (H): ____________ Phone (W): ____________ ext. ______ Phone (C): ____________

Preferred method of contact: ____________________________

Address: ______________________________ City/State: ________________ Zip: ______

Occupation: ______________________ Employer: ______________________

Spouse or Contact person: ____

Drivers License number (if a minor, please use guarantor) Issuing State: _____ Number: ____________

Email: ______________________ May we email you monthly skin care special offers: Y N

Referred by: (please specify in the space provided)

Self ______________________
Newspaper ______________________
Magazine ______________________
Yellow Pages ______________________
Friend ______________________

Relative ______________________
Patient ______________________
Spa ______________________
Employee ______________________
Other ______________________

Reason for today's visit: ____

____

____

Concerns (circle all that apply): loose skin - fullness under chin - folds around mouth - lines and wrinkles - look of neck - look of chest - hands - lips - sun spots - broken blood vessels - Rosacea redness - leg veins - spider veins - frown lines - crow's feet - acne - acne scaring - stretch marks - birthmarks - scars - unwanted hair - skin care products

AUTHORIZATIONS

I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I authorize Dermalogic Laser Center to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Dermalogic Laser Center determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Dermalogic Laser Center.

I understand that I am responsible for any balance due for professional services.
I understand and acknowledge that payments for procedures are non-refundable.
I understand that in the event of collection action, I am responsible for any legal fees incurred.

Signature: ______________________________ Date: ____________

DERMALOGIC Laser Center

Acknowledgment and Consent

I understand that Dermalogic Laser Center of Hammonton, NJ (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I <u>have received</u> a copy of the Notice of Privacy Practices.

By:______________________________ Date:______________________
(Patient)

-OR-

By:____ Date:______________________
(Patient representative)

Description of Representative's Authority____

DERMALOGIC Laser Center

MEDICAL HISTORY

Last name: ______________________________ First name: _____________________________ Middle initial: _________

Date of Birth: ________________

ALLERGIES

List all Allergies: Describe your Reaction:

__________________________ ____

__________________________ ____

__________________________ ____

CURRENT MEDICATIONS

Drug Name (brand/generic) Dosage: Schedule (frequency)

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

PAST MEDICAL HISTORY

Have you ever had any of the following? Please circle all that apply

Anemia	Depression	Heart Disease	Shortness of Breath
Ankle Swelling	Diabetes	Heart Attack	Stroke
Bleeding Tendency	Dizziness	Hearing Problems	Thrombophlebitis
Cancer	Emphysema	High Blood Pressure	Ulcer
Chest Pain	Endocrine Problem	HIV (AIDs)	Vision Problems
Coughing Blood	such as thyroid	Pneumonia	

Illnesses	Date	Hospitalizations	Date	Injuries	Date	List all surgeries	Date

DERMALOGIC Laser Center

HISTORY OF TOBACCO

Have you ever smoked? Yes No If yes, when? ___________________________

Are you currently smoking? Yes No

Cigarettes______ How many a day?__________ How many years? __________

Cigars ________ How many a day?__________ How many years? __________

Smokeless tobacco ____________ How many a day?__________ How many years? __________

HISTORY OF ALCOHOL

Do you drink alcohol? Yes No Recovery Alcoholic? Yes No Probably an Alcoholic? Yes No

Drink Alcohol____ How many times a week?___________ OR times a month? _________

Cigars ________ How many a day?__________ How many years? __________

Preferred beverage? _________________________

COSMETIC HISTORY

Have you had (Restylane, Collagen, etc.) injections? _________ Last injection? _____________

Have you had Botox injections? ____________________ Last injection? ______________

Have you ever been pregnant? YES NO How many times?_____ Live births?___________

Are you currently pregnant? YES NO Are you planning more children? YES NO

Have you used Accutane? __________________ For how long? ______________

Have you recently had facial surgery? _______________ Type and date: ____________________

Have you ever had laser resurfacing? _______________ Type and date: ____________________

Have you had a bad reaction to local or general anesthesia? YES NO If yes, explain _________________________

Have you had significant emotional problems? YES NO If yes, explain _________________________

Have you had psychiatric care? YES NO If yes, explain __________________

Have you seen other plastic surgeons about this same problem? YES NO If yes, explain _________________________

Do you have high blood pressure? YES NO If yes, explain ______________________________________

Do you bleed easily from cuts or surgery? YES NO If yes, explain ______________________________________

Do you form large scars or keloids? YES NO If yes, explain ______________________________________

Do you have frequent infections or boils? YES NO If yes, explain ______________________________________

I hereby consent to be examined and treated by Amy Krachman, DO and that the above information is correct.

____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

Dermalogic Laser Center

Photo Consent & Release Form

I am allowing Dr. Krachman, Dermalogic Laser Center and Dermalogic Med Spa, or a staff member, to take photos and/or video of my treatment session and/or treated areas to be used for the purpose of monitoring my progress. I understand that these photos can be published, online or elsewhere, only with my consent for which I:

▫ **give permission** ▫ **do not give permission**

- At my request my identity & photos will only be used in my medical chart ______ **(initial)**

If granting permission to publish:

- At my request my identity will remain anonymous ______ **(initial)**
- I give permission for my photos to be used for:
    - Dermalogic's Before & After Gallery ______ **(initial)**
    - Advertising & Promotional Purposes* ______ **(initial)**

**This includes Dermalogic's website, email, Facebook & Instagram pages.*

I agree that such photographs, recordings, audio or video, or any reproduction of same in any form, are the property of Dermalogic and Dr. Krachman, and I relinquish any present or future claim for reimbursement (i.e. I will not receive payment) for said photographic or film reproduction or for said testimonials by me.

This release is strictly designed to give permission to Dermalogic to use my digital patient photos for their website, Social Media, and in-office presentation for both educational and promotional purposes. Dermalogic will have permission to use these photos in the manner discussed with me, unless I request the office no longer use them. I understand that by allowing Dermalogic to use my photos, they are able to share "before and after" images to educate and explain procedures and possible results of treatment. I understand that I have the option to decline this request, and am not obligated in any way to provide permission to use these photos.

By signing this form, I acknowledge my consent as initialed above. This consent may be revoked at any time by writing a request or completion of a new form.

Signature ____ **Date** _____________________

Printed Name _____________________________________