Dermalogic laser center

PATIENT INFORMATION

First Name:_____ Last Name:_____ Date of Birth:_____
Phone (C): _____ Preferred method of contact:_____
Address:_____
Gender: Male | Female Email:_____
Referred by: _____(Friend, Social Media, Newspaper, etc.)
Reason for today's visit: _____ (Full Face Assessment, Botox, Fillers, Lasers)

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 - Frown Lines - Crow's Feet - Acne - Acne Scaring - Stretch Marks - Birthmarks - Scars - Unwanted Hair - Skin Care Products - Weight Gain/ Loss - Dark Circles Under Eye- Brows, Dull Skin - Unwanted Hair - Hair Loss -Unwanted Fat - Under Eye Hollows - Moles -Age Spots/ Sun Spots

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

AUTHORIZATIONS

- I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment.
- 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.
- I understand that Dermalogic Laser Center 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 Dermalogic 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.

Notice of Privacy Practices 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 have received a copy of the Notice of Privacy Practices.

Patient Signature:_____ Date:_____

777 S. White Horse Pike, Hammonton, NJ 08037 609.561.0033 dermalogiclasercenter.com

PATIENT MEDICAL HISTORY

Last name:_____ First Name:_____ Date of Birth:_____

ALLERGIES

List of Allergies	Describe your reaction

CURRENT MEDICATIONS

Drug Name	Dosage	Frequency

PAST MEDICAL HISTORY

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

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

Illnesses | Date	Hospitalizations | Date	Facial Surgeries | Date

HISTORY OF TOBACCO
Have you ever smoked? Yes/ No Are you currently smoking? Yes / No

HISTORY OF ALCOHOL
Do you drink alcohol? Yes / No. How frequently? _____

COSMETIC HISTORY

Dermal Filler | Date	Botox, Dysport | Date	Laser Procedures | Date	Aesthetician Services

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

_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

_____
DATE