



PATIENT REGISTRATION

Patient Name: _____ Date of Birth: _____

Guardian's Name: _____

Patient Address: _____

Home Phone: _____ Work /Cell Phone: _____ / _____

Emergency Contact: _____ (_____)
Name Phone

How did you hear about Cascade Cosmetic Center? _____

Would you like to be on our mailing list? Yes No

Would you like to receive e-mails from us regarding monthly specials? Yes No

E-mail Address

History

Are you under a physician's care? Yes No

Have you undergone any surgeries in the past 9 months? Yes No

If YES, please specify: _____

Do you have any allergies? Yes No

If YES, please specify: _____

List any medications you take regularly: _____

Do your wounds heal slowly? Yes No

Are you or have you ever been on Accutane? Yes No

FEMALE:

Are you pregnant or trying to become pregnant? Yes No

Are you lactating? Yes No

Are you taking an oral contraceptive? Yes No

MALE:

Do you experience irritation from shaving? Yes No

Do you experience ingrown hair? Yes No

~PLEASE CONTINUE ON BACK~

Have you had any of these health problems in the past or present?

- | | | |
|-----------------------------------|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hormone Imbalance | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Rosacea | <input type="checkbox"/> Herpes (cold sores) | <input type="checkbox"/> HIV/AIDS |

Do you use a sunscreen daily? Yes No

Do you sunburn easily? Yes No

Does your skin have reddening tendencies? Yes No

Do you experience acne breakouts regularly? Yes No

If so, where? _____

Do you experience oily shine during the day? Yes No

Do you ever experience:

● Flakiness Yes No

● Tightness Yes No

● Dryness Yes No

I confirm that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Signature of Patient or Patient's Guardian

Date

Private Practice Policy

Federal law requires that the Notice of Privacy Practices, which is our explanation of how we use and disclose your health information, be made available to patients. This law also requires that each individual acknowledge that you have been advised of the policy.

You have the right to review our notice, and if you have any questions, to ask for an explanation of any part of the Notice, or any other aspect of our use and disclosure of your health information. The terms of our Notice may change as the law and our practice change. If we change our Notice, we will have revised copies available to you when you visit us, and also send you a revised copy upon your request.

Your signature acknowledges that you have received or have been offered and refused, a copy of our Notice.

Information regarding my healthcare may be released to the person(s) listed below.

Name: _____ Relationship: _____

Cancellation & No Show Policy

There will be a \$50.00 fee to all patients who no show or fail to cancel cosmetic appointments without 24 hours notice. Additional Fraxel & Sculptra fees will apply, amounts are specified in patient contracts.

Patient / Representative Signature

Date

Print Patient Name