CASCADE Cosmetic Center

# 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?

| | | |
|---|---|---|
| □ Cancer | □ Heart Problems | □ Tuberculosis |
| □ Diabetes | □ Hormone Imbalance | □ Hepatitis |
| □ Epilepsy | □ Thyroid | □ Liver Disease |
| □ Rosacea | □ Herpes (cold sores) | □ 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