PATIENT REGISTRATION

PATIENT INFORMATION:

PATIENT NAME		**PREFERRED TO BE CALLED:**	**DATE OF BIRTH:**
ADDRESS:		**CITY & STATE:**	**ZIP CODE:**
HOME PHONE:	**CELL PHONE:**	**WORK PHONE:**	
EMPLOYER:		**SPOUSE NAME:**	
EMAIL ADDRESS:		*Your email address will only be used for information mailings and will not be sold or given to any 3rd party.*	

REFERENCE:

HOW DID YOU HEAR ABOUT COSMEDIC SKINCARE:	

RESPONSIBLE PARTY (if different from patient):

NAME:	**RELATION:**
ADDRESS, CITY, STATE ZIP:	**CONTACT NUMBER:**

IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME:	**RELATION:**	
HOME PHONE:	**WORK PHONE:**	**CELL PHONE:**

FINANCIAL RESPONSIBILITY AGREEMENT:

- We are not contracted with any insurance company; however we can provide you with a superbill that you can submit to your insurance company for reimbursements.
- Payment is due at the time of service. We accept payment in the form of credit/debit card, cash and check.
- Payment plans are available through SurgeryLoans and CosmetiCredit.
- Returned checks are charged a $30 fee.
- NO SHOWS may be subjected to a fee of $45 if appointments are not cancelled at least 24 hours in advance.
- If you NO SHOW or cancel within 24 hours a credit card must be used to hold your next appointment.
- A 10% deposit must be taken for all CoolLipo procedures.

I further understand that providing proof of my insurance plan(s) or explanation of benefits does not hold Cosmedic Skincare and the Center for Medical Weight Loss responsible for verifying this information. I accept full financial responsibility for medical expenses incurred at the Cosmedic Skincare for all services provided. In the event where it is necessary to refer my account to an attorney for collection, I am responsible for all fees and expenses.

_____ _____

Signature (if under 18, must be signed by parent/guardian) Date

_____

If parent/guardian, print name

[Optional] **Procedures or products of interest to you (please check all that apply)**

- ❑ Dermal Filler (Juvederm, Radiesse, Restylane, Collagen)
- ❑ BOTOX® Cosmetic (Botulinum Toxin Type A)
- ❑ Laser Lipo-Body Sculpture
- ❑ Thermage
- ❑ Laser/Light Treatments (IPL / Isolaz)
- ❑ Skin and Hand Rejuvenation
- ❑ Chemical Peels
- ❑ Micro-Dermabrasion
- ❑ Permanent Make-up
- ❑ Sclerotherapy
- ❑ Melanage Peel
- ❑ Hair Removal
- ❑ DOT Resurfacing
- ❑ Eyebrow wax/tint
- ❑ Subscission
- ❑ Other, Please Specify: _____

Skincare Products

- ❑ Neocutis ❑ Other
- ❑ Jan Marini ❑ ProCyte
- ❑ Belle Derm ❑ Ti-Silk
- ❑ Belle Pierre (Mineral Make-up)
- ❑ TretinX ❑ Obagi

HEALTH HISTORY QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire. The information you provide will help us attend to your specific health care needs. We not only value this information but also your input and participation in your medical care.

NAME: _____ AGE: _____

S **SKIN IS GENERALLY** (Please check all that apply)**:**

- ❑ Acne Scars
- ❑ Big Pores
- ❑ Blotchy
- ❑ Broken Capillaries
- ❑ Cysts
- ❑ Dark Circles
- ❑ Acne
- ❑ Dry Skin
- ❑ Easily Red
- ❑ Excess Hair
- ❑ Flaky
- ❑ Tanned easily
- ❑ Darkens Easily
- ❑ Oily
- ❑ Puffy Eyes
- ❑ Wrinkles
- ❑ Sensitive
- ❑ Herpes
- ❑ Skin Tags
- ❑ Spider Veins
- ❑ Sun Damage
- ❑ Skin Cancer/ pre-cancer
- ❑ Warts
- ❑ Allergies

In order of preference, please list all concerns that relate to your skin.

_____

_____

What are your current skin care regimens?

Face:_____

Body:_____

What treatments/medications have you HAD for these conditions?

Topical_____ Oral_____

What medications and/or vitamins are you currently taking?

_____

_____

How long have you had this/these condition(s)? _____

PATIENT HISTORY:

Primary Physician:_____ City/State:_____

Last Physical:_____ Last Blood Work:_____

Drug Allergies:_____ Food Allergies:_____

Health Concerns/Issues:

_____

Health History: _____

_____

Skin Conditions and Treatments:_____

Women Menstrual Cycle: ❑Regular ❑Irregular

# of Children _____ ❑ Birth Control ❑ Planning Children ❑ Pregnant ❑ Nursing

FAMILY HISTORY:

❑Acne ❑Rosacea ❑Psoriasis ❑Diabetes ❑Thyroid ❑Rashes ❑Depression ❑Melanoma ❑Moles

❑Heart Problems ❑High Blood Pressure ❑High Cholesterol ❑Pre-Cancer ❑Skin Cancer

Major family health issues? _____

_____

Before and After Photo Release
for *Cosmedic Skincare and*
the Center for Medical Weight Loss

I consent to being photographed before, after and potentially during any procedures at Cosmedic Skincare and the Center for Medical Weight Loss. I understand that these photographs will become part of my confidential medical record stored on Dr. Reinertson's computer and/or in my patient chart. I understand that the images are the property of Dr. Reinertson but that I may request copies for a nominal fee.

Please initial all that apply:

___ I give my consent for the physician to use my pictures at medical meetings and/or in the publications of medical article(s).

___ I give my consent for the physician to use pictures of my procedure results to show other individuals interested in the same procedure so long as my name is kept confidential.

___ I give my consent for the physician to place my picture on Cosmedic Skincare's website www.seattlecosmedicskincare.com as long as my name is kept confidential.

OR

___ I give my consent to have my pictures taken to be kept for my records.

___ I do not want to have my pictures taken.

Please print your name: _____

Signed: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed by Cosmedic Skincare and the Center for Medical Weight Loss. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 206-622-6444 or by requesting one at this office.

_____ _____

Date Signature*

_____

Print Name

- As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

_____ _____

Date Signature

_____

Relationship