Dermatology Professionals
Cosmetic Registration Forms

Patient Information (please print)

Name: _____
Last First M.I.

Address:_____
Street Apt. # City State Zip

DOB:_____

Telephone Home:_____ Cell:_____

Telephone (Work):_____ Email Address:_____

How did you hear about us? _____

Name of Emergency Contact:_____ Phone Number:_____

May we leave voicemails reminding you of your upcoming visits? YES / NO

Consent to Medical Care

In order to provide you with medical care, we need to have written consent from you Dr. Taylor will be happy to address any question or concerns you may have about your condition or treatment. I give my permission to Claudia Taylor, M.D., and staff, to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition.

_____

Signature of Patient (or guardian) Date

PHOTO AND TESTIMONIAL RELEASE FORM

I hereby grant permission to Dermatology Professionals to use my photograph relating to before and after photos that I receive in this office. I authorize the use of photographs in any marketing, advertising or teaching materials used to market or advertise Dermatology Professionals, including use on the Dermatology Professional's website. I permit Dermatology Professionals the right to crop or otherwise treat the photograph to its discretion. I also acknowledge that Dermatology Professionals may choose not to use my photograph and testimonial at this time, but may do so at a later date. I also understand that once my image is posted on the Dermatology Professionals website, the image can be downloaded by any computer user, which is beyond the control of Dermatology Professionals.

I hereby freely and voluntarily consent to the use of my photograph and testimonial as stated above until I revoke this consent in writing.

_____

Signature of Patient (or guardian) Date

Cosmetic Financial Policy

Dermatology Professionals is determined to provide the most comprehensive medical and cosmetic care to our patients. Our goal is to give the highest level of patient care, quality of services and innovative treatments to address your needs and exceed your expectations.

It is our pleasure to assist you in reaching your aesthetic rejuvenation goals. We strive to inform our patients of all the treatment costs associated with any recommended procedure as well as to advise you on our payment policies.

Consultation Fees

The fee for a cosmetic consultation is $100.00 and is due at time of scheduling the appointment to hold the appointment time. If, after your consultation, you choose to move forward with the recommended treatment plan, the consultation fee will be applied to the procedure for up to a year after the initial consultation.

Office Treatment Fees

Fees for treatments such as Botox®**,** Juvederm®**,** laser hair removal, vascular lesion removal, and other similar procedures are priced either on a per session basis or as a treatment package, and are payable in full at the time of your appointment. Individual sessions and packaged treatments are non-refundable, however these treatments are transferable to other procedures offered in our clinic. These treatments require a $100 deposit to schedule. In addition, Botox® treatments require a minimum of 16 units per treatment. Deposits are non-refundable. An appointment can be moved and deposit applied to a different date of service if patient notifies the practice with a minimum of 36 hours before their scheduled appointment.

Skin Care Products

We accept returns on skin care products within 30 days of purchase for a refund or exchange. Deposits on appointments do not apply towards skin care product purchases.

Payment Options

We accept Visa, Mastercard, Discover, Cash and Personal Checks as forms of payment. We also recommend CareCredit, a special financing program available to patients at low interest rates. With CareCredit you can finance your cosmetic procedures without upfront costs, annual fees, or pre-payment penalties. Please inquire with our staff for more information.

Quotes provided in our office are preliminary. Although rare, instances arise which can alter originally quoted procedures. In this event, increases or decreases maybe made to the original quote. If this occurs you will be notified of such a change prior to the procedure so that you can make an informed decision as to how you would like to proceed with treatment. It is important that you understand that all services are non-refundable. We make every effort to keep you informed regarding your medical care in our practice as well as your financial responsibility at all times.

Notice of Patient Privacy Acknowledgment and Consent

We are required by law to protect the privacy of your medical information and to provide you with written notice describing: HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may use or disclose your medical information both created and received by this practice for purposes of providing or arranging for your health care. This may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. This may also include information regarding payment for or reimbursement of the care that we provide to you, and any related administrative activities supporting your treatment.

We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information,, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise this notice from time to time. You have the right to receive a copy of our most current notice in effect. If you have not yet received a copy of out current NOTICE OF PRIVACY PRACTICES, please ask at the front desk and we will provide you with a copy.

If you have any questions about the NOTICE OF PRIVACY PRACTICES or your medical information, please contact our office at 503-344-6643.

Signature of Patient (or guardian) Date

Name:_____ **PCP:**_____

History and Intake Form

Past Medical History: ***(please circle all that apply)***

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Other _____
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None

Past Surgical History: ***(please circle all that apply)***

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Skin Disease History: ***(please circle all that apply)***

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

Location of skin cancer, type of treatment and date:
_____
_____
Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Tanning salon use (past or present)? Yes No How often?_____

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications)
_____
_____
_____

Allergies to medications:
_____
_____

Social History: (Please circle all that apply)
Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Alcohol usage:
- None
- Less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

Occupation ***(former occupation if retired)***:_____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring		
Immunosuppression		
Changing mole		
Rash		
Abdominal pain		
Anxiety		
Bloody stool		
Bloody urine		
Blurry vision		
Chest pain		
Cough		
Depression		
Fever or chills		
Headaches		
Hay fever		
Joint aches		
Muscle weakness		
Neck stiffness		
Seizures		
Shortness of breath		
Sore throat		
Thyroid problems		
Unintentional weight loss		
Wheezing		
Asthma		

Other Symptoms: _____

Alerts:
(***Check any of the following that apply to you)***

Alert	Yes	No
Pacemaker		
Defibrillator		
Artificial joints within past two years		
Artificial heart valve		
Premedication prior to procedure		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners		
Pregnancy or planning a pregnancy		
Allergy to lidocaine		
Rapid heart beat with epinephrine		
Yeast infection with antibiotics		
GI upset with antibiotics		

Other Symptoms: _____