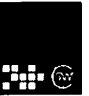
COSMETIC PATIENT REGISTRATION

THE SKIN WELLNESS CENTER 

Date ________________ Provider ______________________

Patient's Full Name (legal) ____ Patient # ________________

Address ____ City ______________ State _____ Zip __________

Home Phone ____________________ Work ____________________ Cell Phone ________________________

Primary Phone Number: Home ☐ Work ☐ Cell ☐ Where may we leave messages? Home ☐ Work ☐ Cell ☐

Email ____ Would you like to receive emails about our specials? Y N

Birth Date _____________ SS# ______________________ Sex: M F Marital Status __________

Occupation ___________________________ Employer/School _______________________ Phone _____________

Race ____________ Preferred Language _____________ Ethnicity (Hispanic or Not Hispanic) ______________________

Notify in Emergency ___________________________________ Phone______________ Relationship ____________

Primary Care Physician______________________________

Please list any medications and vitamin supplements you are currently taking: ____

____

Please list any medication allergies: ____

____

Are you currently pregnant or nursing? Y N Height__________ Weight__________

Financial Responsibility (if different than above)

All minors must be accompanied by a parent or legal guardian

Name __________________________________ Birthdate ___________ Phone ___________ SS#____________

Address ____ City _________________ State _____ Zip __________

Employer _________________________________ Phone _____________ Relationship to Patient _______________

INITIAL

______I understand that I have a maximum of 14 days to return products that I am dissatisfied with.

______I understand that The Skin Wellness Center does not provide refunds for returned products and a credit for the return amount will be applied to my account at The Skin Wellness Center.

______I understand that I am required to pay for products and services rendered at the time of visit.

______I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices.

Is there anyone you would like to give us permission to speak to regarding your care? ______________________________

Relation ________________

_______________________________________ ________________ ________________

Signature of Patient or Patient's Representative Relation to Patient Date

COSMETIC CONSULTATION

THE SKIN WELLNESS CENTER

Patient Name ______________________ Date: ____________ Patient # ____________

Please mark any services that you want to discuss:		*Please mark any specific problem areas that you want to discuss:*	
◯ Fillers	◯ Botox/Dysport	◯ 11's (frown lines between the eyes)	◯ Brows
◯ Laser Genesis	◯ Juvederm	◯ Crow's Feet	◯ Brown Spots
◯ Permanent Makeup	◯ Voluma	◯ Forehead	◯ Scars
◯ Clear & Brilliant	◯ Sculptra	◯ Cheeks	◯ Acne
◯ Peels	◯ Restylane Silk	◯ Lips	◯ Leg Veins
◯ Fraxel	◯ Restylane Lyft	◯ Face	◯ Eye Lashes
◯ IPL/Fotofacial	◯ Radiesse	◯ Chest	◯ Under Arm Fat
◯ Sclerotherapy	◯ Kybella	◯ Chin	◯ Facial Veins
◯ CoolSculpting	◯ HydraFacial	◯ Abdomen	◯ Hands
◯ Laser Rejuvenation	◯ ________	◯ Love Handles	◯ Back
◯ Laser Hair Removal	◯ ________	◯ Thighs	◯ Arms
◯ Products	◯	◯ Legs	◯

Please list all medications and vitamin supplements you are currently taking:

____

Please list any medication allergies:

____

Have you had any sun exposure, used a tanning bed, or used self-tanning products within the last 4 weeks? _____ Yes _____ No

Are you or do you think you might be pregnant? _____ Yes _____ No

Have you been treated with Accutane or similar medication in the past 6 months? _____ Yes _____ No

Do you have an allergy to sulfa? _____ Yes _____ No

Do you have a history of herpes/cold sores? _____ Yes _____ No

Do you have a history of keloids/hypertrophic scarring? _____ Yes _____ No

Do you have a pacemaker/defibulator? _____ Yes _____ No

Do you have any permanent/tattooed makeup? _____ Yes _____ No

Do you have any metal implants in the area you are interested in treating? _____ Yes _____ No

How tall are you? __________ How much do you weigh? __________

What is your current skin regiment?______________________________

Please list any previous treatments: ______________________________

Summary of Visit

Treatment area ______________________________

Quoted # of treatments ______________________________

Quoted price ______________________________

Pre/Post given ______________________________

Brochures given ______________________________

Samples given ______________________________

Products Purchased ______________________________

Comments ______________________________

PRACTICE INFORMATION

THE SKIN WELLNESS CENTER

Patient Name ________________________________ Date ___________ Patient # _____________

Your Appointment

Your time is important to us. Your appointment time was scheduled based on the reason you gave us when you scheduled your appointment. If you have additional problems or need to discuss additional concerns with your provider, we will have to schedule another appointment to address these problems / concerns. This will allow us to be considerate of all our patients' time.

Late Arrivals

Out of respect for other patients arriving on time, if you arrive more than 15 minutes late, you may be asked to reschedule. However, arriving less than 15 minutes late DOES NOT guarantee that you will be seen. It is at the discretion of your health care provider whether you can be worked back in to the schedule.

Your Prescriptions

Unless you request a written prescription to take with you after your visit, prescriptions are sent electronically to your pharmacy. This often means that your prescription will not be ready for pickup until the end of the day. We strongly suggest you call your pharmacy to make sure your prescriptions are ready before going to pick them up.

Insurance companies often change their list of "preferred drugs". We try very hard to keep current with these changes. However, you may find that your insurance company has rejected your prescription because it is not on their "preferred list". Again, we suggest you call your pharmacy to make sure your prescription(s) are ready before going to pick them up. If your prescription is rejected by your insurance because it is not on their "preferred list", additional time will be required for approval of a substitute medication.

Cancellation/No-show Policy

We respectfully ask for 24 hours notice if you will be unable to keep an appointment. You may be charged a $25 fee for not showing for an appointment without giving us notice.

Co-pays and Fees for Service

All co-payments or payments for services rendered are expected at time of visit. If you are unable to pay your co-pay at time of visit, there will be an additional $8 fee added to your bill.

Consent to Treat Minors

Minors, persons under the age of 18, must be accompanied by a parent or legal guardian for all appointments. If it is necessary for a minor to come to appointments alone or with a friend or family member, we must have a statement in writing from a parent or legal guardian giving us permission to treat your child without the parents' presence. We have a form for minor consent that we can provide upon request.

Cell Phone Usage

Please be respectful of our employees, providers, and other patients by refraining from cell phone use while in our waiting and check in area and the exam rooms.

Lab

We participate only with Dermatopathology Partners, P.C. for all biopsy samples. Your insurance will be billed by Dermatopathology Partners and you are responsible to Dermatopathology Partners for any balance due after insurance.

For all other labs (blood work, urine samples) we use PathGroup which participates with most insurances. If your insurance plan requires you to use a different lab, please notify us at the time of your visit.

I acknowledge that I have read and understand the above statements and all questions have been answered to my satisfaction.

______________________________________ ______________

Signature of Patient or Patient's Representative Date