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Medical History, Authorization & Questionnaire for Cosmetic and/or Laser Procedures

Reason for today's visit: ____

CONCERNS (circle all that apply): Lines & Wrinkles - Frown Lines – Crow's Feet – Folds around mouth – Loose Skin -Fullness under chin Appearance of Neck, Chest Area, Hands, Lips – Sun Spots – Broken Blood Vessels – Rosacea- Redness-Leg Veins – Spider Veins – Acne Acne Scarring – Stretch Marks – Birthmarks – Scars – Unwanted Hair – Skin Care Products

Other: ____

AUTHORIZATION I, the undersigned, authorize treatment and agree to pay the Dermatology Center of Washington Township all fees and charges for treatment when services are rendered. I authorize The Dermatology Center of Washington Township to disclose any information they determine to be necessary for the purpose of medical treatment, medical quality assurance and peer review. This includes copies of notes and/or photographs when necessary.

I understand and acknowledge that payments for procedures are non-refundable. __________ (initials)
I understand that in the event of collection action, I am responsible for any legal fees incurred. __________ (initials)

Signature: ______________________________ **Date:** ____________________

COSMETIC HISTORY

Have you seen any plastic surgeons about this present concern? YES NO If yes, explain ____________________

Have you had Restylane, Juvederm, Collagen, etc. injections? ____________________ Last injection: ____________________

Have you had Botox injections? __________ Last injection: ____________________ Any adverse reactions? ____________________

Have you ever been pregnant? YES NO How many times? ______________ How many live births? ____________________

Are you currently pregnant? YES NO Are you planning more children? YES NO

Have you taken Accutane? YES NO If yes, for how long? ______________ Date of last course: ____________________

Have you recently had facial surgery? ________ Type & date: ____________________ Dr: ____________________

Have you ever had laser resurfacing? ________ Type & date: ____________________ Dr: ____________________

Have you ever had a reaction to local or general anesthesia? YES NO If yes, explain ____________________

Have you had psychiatric care? YES NO If yes, explain ____________________

Do you have high blood pressure? YES NO Do you take blood thinners? YES NO Do you form large scars or keloids? YES NO

Do you bleed easily from cuts or surgery? YES NO If yes, explain ____________________

Do you have frequent infections or boils? YES NO If yes, explain ____________________

I HEREBY CONSENT TO BE EXAMINED AND TREATED BY AMY KRACHMAN, DO AND THAT THE ABOVE INFORMATION IS CORRECT.

Signature of patient or responsible party: ______________________________ **Date:** ____________________