Avatar Aesthetics
laser center

Confidential Patient Health Record
Photo-Dermatology

Name: _____ Today's Date: _____

Address: Date of Birth: _____Age: ____

City: _____ Sex: ____Male ____Female

State: _____Zip: _____ Home Phone: _____

Referred by: _____ Work Phone:

Emergency Contact: _____ Cell Phone:

Phone: E-Mail:

Relationship:

I am interested in the following services:

- ☐ Laser Hair Removal
- ☐ Laser Lipolysis
- ☐ Nonsurgical facelift/ bodylift
- ☐ Microdermabrasion
- ☐ Photodermatology
- ☐ Laser Tattoo Removal
- ☐ Dermal or Epidermal Lesion Removal (including sun spots, liver spots, birthmarks, café au lait spots)

Primary Care Doctor:_____Number:_____

Current Health Condition(s)_____

Prescription & Over the Counter Medication(s) _____

_____

Doctor Signature _____ Date _____

Please check if you have any of the following: Photo-Dermatology

- ☐ Acute disease
- ☐ Fever
- ☐ Using/ taking photosensitive medications
- ☐ Malignancy
- ☐ Infectious Disease
- ☐ Pregnant or Nursing
- ☐ Heart Diseases and conditions
- ☐ Sun sensitivity
- ☐ Patients receiving Treatment elsewhere
- ☐ Epilepsy or photophobia

Please list any conditions not mentioned above:

_____

_____

The above information is true to the best of my knowledge, and I will inform the staff of Photobiotech Laser Aesthetic Center of any changes to my health conditions.

Patient Signature: _____ Date: _____

Cancellation Policy

Your appointment time is reserved especially for you; this includes the room, machine, and the technician performing your service. Please be advised for no shows, cancellations, or reschedule requests with less than 24 hours' notice, the session may be either forfeited from the treatment package (if applicable) or subject to a cancellation fee of $25. Thank you for your consideration.

_____ (please initial) I have read and understand the cancellation policy

Acknowledgment of Receipt of Notice of Privacy Practice

I, _____(Patient's Name), acknowledge I have received, reviewed, understand and agree to the Notice of Privacy practices of Avatar Aesthetics, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the practice.

Signature:_____Date:_____