



Avatar Aesthetics  
laser center

## Confidential Patient Health Record Tattoo or Dermal/Epidermal Lesion Removal

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:**

- |  |  |
|--|--|
| <input type="checkbox"/> Laser Hair Removal              | <input type="checkbox"/> Photodermatology  |
| <input type="checkbox"/> Laser Lipolysis                 | <input type="checkbox"/> Laser Tattoo Removal  |
| <input type="checkbox"/> Nonsurgical facelift/ body-lift | <input type="checkbox"/> Dermal or Epidermal Lesion Removal<br>(including sun spots, liver spots,<br>birthmarks, café au lait spots) |
| <input type="checkbox"/> Microdermabrasion               |  |

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: Tattoo or Derm/Epiderm Lesion Removal**

- Cancer
- Topical antibiotic use
- Recent sun exposure
- Products that cause photo-sensitivity
- Retinoid use (this includes Acitretin, Alitretinoin, Bexarotene, Isotretinoin (Accutane), and Vitamin A.)

**Please list any conditions not mentioned above:**

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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 the full service. 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:** \_\_\_\_\_