DERMATOLOGY AND LASER CENTER NW

Dr. Corrine Hecht
Dr. Jan Dank
Deborah Sherman-Groda, PAC
Amy Classen, Master Aesthetician

Aesthetician Registration:

Last name: _____First: _____ Middle Initial: _____

Date of birth: _____ Sex: M F U Address: _____ Apt/Ste #: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Preferred phone: _____Alt phone: _____ Work Ph: _____

I consent to allow the aesthetician and staff at Dermatology and Laser Center NW to leave a detailed message at my preferred phone number and/or email (PHI). I understand this may include information regarding appointments as well as personal medical or financial information related to my care.

(Optional). _____ _____ Initial: _____
Phone Date

Notice of Privacy Practices (NPP) Acknowledgement_____ Initial:_____
Dermatology & Laser Center NW has a responsibility to protect the privacy of your health care information & to provide a NPP that describes how your health care information may be used & disclosed, how you can access your health care information, and whom to contact if you have concerns. We may change NPP at any time if required by HIPAA. You may contact our Privacy Officer at 360-676-1470. I agree I have received the NPP.

Financial Policy _____

- Payment due at time of service for cosmetic visits, cosmetic procedures, and retail purchases.
- We accept debit, Visa, MasterCard, Discover, and Care Credit (OAC). Care Credit option must be chosen at the time of treatment.
- Short-Notice Cancellation or No-Show: If you fail to show OR do not cancel with 24 hours' notice a $50 fee will be charged to your account. As a courtesy, we will deliver a reminder call, text, & email prior to your visit. Failure to receive notifications will not excuse the fee.
- Accounts past 90 days will be sent to an outside collection agency. $25 fee for NSF/returned checks.

Reason for today's visit:_____

List 3 things/areas about your skin you would like to improve:

_____

_____

_____

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List all current prescriptions medications: (include over-the-counter vitamins & herbals):

_____

_____

_____

I have allergies to medications. YES NO If Yes, please list medications and reactions you had:

_____

Circle below if applies:

Acne Rosacea Eczema Psoriasis Diabetes Hepatitis

Skin cancer HIV or AIDS Immune Suppression History of Accutane-(year completed?)

Yes No I am currently pregnant or currently nursing
Yes No I am planning a pregnancy
Yes No I smoke cigarettes. If Yes, amount_____
Yes No I drink alcohol. If Yes, amount/type _____
Yes No I have a history of blistering sunburn(s)
Yes No I have a history of using tanning beds
Yes No I wear sunscreen daily
Yes No I occasionally have cold sores on my lips
Yes No I take blood thinner medications
Yes No I have hypertrophic scarring
Yes No I have a lidocaine allergy

I have had the following facial surgeries/procedures (circle):

Face Lift Neck Lift Brow Lift Blepharoplasty/Eyelid Lift (U/L):____

Rhinoplasty (cosmetic nose surgery) Thermage/other skin tightening procedure

IPL (photofacial)/CO2/Fractional Laser Resurfacing Botox/Xeomin/Dysport Fillers

Cheek Implant Chin Implant Chemical Peel Microneedling

Printed name of patient or responsible party (party/guardian): _____

Signature: _____ Date: _____

7.2021