

# Northwest Dermatology Skin Care Clinic

## Patient Consultation

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Alternate Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Health Questionnaire: mark what applies to you

<input type="checkbox"/> Anemia	<input type="checkbox"/> Stroke	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Bleed Easily	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Cancer-Tumor	<input type="checkbox"/> Dark Spots	<input type="checkbox"/> Skin Lesion/Cancer
<input type="checkbox"/> Moles	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hysterectomy/Menopause
<input type="checkbox"/> Keloids	<input type="checkbox"/> Asthma	<input type="checkbox"/> Eye/Vision Problems
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Liver/Hepatitis	<input type="checkbox"/> Heart Disease
Smoke/How much? _____		
Alcohol/How much? _____		
Medications/Supplements _____		

### Photographic Consent:

I authorize the Medical Aesthetician to take photographs for procedure(s) performed on me. I understand that the photographs are property of Northwest Dermatology Skin Care Clinic. The Photographs will not be released to any other physician, clinic, or agency with out my written permission.

I agree that the Northwest Dermatology Skin Care Clinic may use the photographs in educational training with medical personnel, or in presentations at any time following my treatment.

Patient Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

Date: \_\_\_\_\_

### POLICIES: I understand fully and agree to comply with all the policies below:

1. We do not wax anyone on Accutane, Retin-Q, or other medications/products that thin the skin.  
We do not wax anyone under going chemotherapy or radiation treatments.
2. We require a minimum of 48 hrs advance cancellation notice. Any client giving less THAN 24 MAY BE CHARGED 1/2 THE SERVICE FEE.
3. I understand that the services received here are not a substitute for medical care and any information provided by the Medical Aesthetician is for educational purposes only.
4. We do not give cash or credit refunds.
5. Defective products must be returned within 14 days of purchase to receive credit.

Patient Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

Date: \_\_\_\_\_