

Patient Information

Patient Name: _____ Home Phone: _____

May we send appointment reminders via text message? Yes No Cell Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

SS# _____ Date of Birth: _____ Age: _____ Sex: M F

Marital Status: S M W D Email Address: _____

Employer: _____ Occupation: _____ Phone: _____

Spouse/Additional contact: _____ Phone: _____

Cell Phone: _____

How Did You Hear About Us? _____

We provide our patients with a quarterly informative newsletter – please check here if you do NOT want to receive promotional mailings

Medical History Current Illnesses: _____ Reason for Visit _____

Current Medications: _____

Drug Allergies: _____

Pregnant? YES NO DATE _____ Breast Feeding? YES NO DATE _____

Recent Sun Exposure: YES NO DATE _____ Previous Laser Treatments: YES NO DATE _____

Hair Removal: YES NO DATE _____ Accutane (last 6 months): YES NO DATE _____
(Waxing Plucking, Electrolysis)

Gold Therapy: YES NO DATE _____ Blood Thinners: YES NO DATE _____

Herpes/Cold Sores: YES NO DATE _____ Vitligo: YES NO DATE _____

History of Melanoma: YES NO DATE _____ Keloids/Hypertrophic Scarring: YES NO DATE _____

Tattoos/Permenant Make-up: YES NO DATE _____ Fillers, Botox, etc. YES NO DATE _____

Pacemaker/Defibrillator: YES NO DATE _____ Implants/Surgeries in treatment area YES NO DATE _____

Skin Type: OILY NORMAL DRY

Skin Classification: SUN-DAMAGED HYPERPIGMENTED ACNE PRONE HYPERSENSITIVE COMBINATION

Consent for Treatment:

I consent to the skin care treatment deemed necessary by the Licensed Aesthetician. I have been informed of the risks and possible outcomes in a way that I understand.

Signature: _____ Date: _____

Signature of Patient Legal Guardian: _____ Date: _____

Use and Disclosure of Health Information

I understand that as part of my healthcare, David B. Reath, M.D. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Information Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice prior to signing this consent. I understand that David B. Reath, M.D. reserves the right to change the Notice of Information Privacy Practices and should information practices change, I will be notified upon my next visit to David B. Reath, M.D.

Signature of Patient or
Legal Representative

Date

**The personal
approach
to personal
change.**