OREGON DERMA CENTER

Dr. Jason Black
971-229-2185
829 NE Hwy 99W
McMinnville, Oregon 97128
www.OregonDermaCenter.com

Refresh, Revitalize, Restore

WELCOME TO OREGON DERMA CENTER!

Thank you for selecting our practice! So that we may best serve you, please fill out this form as accurately as possible and return it to our receptionist. If you have any questions or need assistance, please ask us – we are happy to help. Thank you.

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Date of Birth: _____ AGE: _____

Gender: ☐ Female ☐ Male ☐ "X" STATUS: ☐ Minor ☐ Single ☐ Married/Domestic Partnership ☐ Divorced/Separated ☐ Widowed

Mailing Address: _____City: _____ State: _____ Zip: _____

EMAIL: _____ Phone Number: _____ ☐ Home ☐ Mobile Text reminders? ☐ YES ☐ NO

Ethnic Background: ☐ African-American ☐ Caucasian ☐ Hispanic/Latino ☐ Indian ☐ Native American ☐ Other_____

How were you referred to our office? _____

EMERGENCY CONTACT:

Who should we contact in case of EMERGENCY:

Name: _____ Phone Number: _____ Relationship _____

Name: _____ Phone Number: _____ Relationship _____

MEDICAL HISTORY:

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Primary Care Physician: _____

- Do you have any autoimmune, blood or clotting disorder? ☐ YES ☐ NO If YES, please list _____

  _____
- Do you take/use any medications, herbal/ natural supplements or topical treatments on a regular or daily basis? ☐ YES ☐ NO

If YES, please list names and dosages: _____

_____

Today's Date: _____

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- Do you have any allergies to medications, foods, latex, or other substances? ☐ YES ☐ NO If "YES", please list: _____
  _____
- Do you have a history of any of the following conditions? ☐ Syphilis ☐Hepatitis ☐ HIV/AIDS ☐ Psychiatric Problems
  ☐ Herpes Simplex ☐ Smoking ☐ Alcohol ☐ Cold Sores ☐ Fever Blisters ☐ Other: _____

If "YES", when was your last outbreak and are you currently taking a suppressant medication? _____
_____

Do you have any history of cancer's including skin cancer in your family? ☐ YES ☐ NO If "YES", please explain:_____
_____

Do you have any history of Diabetes, High Blood Pressure, or any heart disease? ☐ YES ☐ NO If "YES", please explain: _____
_____

Do you have a pacemaker? ☐ YES ☐ NO If "YES", please explain: _____

Have you had recent exposure to the sun? ☐ YES ☐ NO If yes, how long ago? And how often? _____.

- Do you use tanning beds, self-tanners or use sunscreen daily? _____
  _____
- Which of the following describes your skin? ☐ Dry ☐ Oily ☐ Normal/Combination ☐ Acne Prone

Have you used any of the following? ☐ Retin-A ☐Accutane ☐Benzoyl Peroxide ☐Retinoids/Retin-A ☐Salicylic Acid ☐Glycolic Acids ☐ Alcohol

- Please describe your current skincare routine and products that you use: _____
  _____

Have you ever undergone a cosmetic procedure? ☐ YES ☐ NO If yes, what have you had done? _____
_____

- Were happy with your results? _____
  _____
- What are your main interests for today's visit?: _____
  _____

BY SIGNING BELOW, I ACKNOWLEDGE THAT THE INFORMATION ON PAGES 1–3 HAS BEEN COMPLETED AND IS ACCURATE TO THE BEST OF MY KNOWLEDGE:

X_____ Date: _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR OR RESPONSIBLE PARTY

Today's Date: _____

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LEGAL AGE AND DISCLOSURE OF MEDICAL HISTORY

I certify that I am a competent adult of at least 18 years of age. If the patient is not of legal age, the undersigned certifies that I am the patient's custodial parent or legal guardian and that I have full power and authority to consent to the treatment on behalf of the minor patient. I will disclose a full and accurate personal medical history, including any and all information regarding medical conditions and use of medications, drugs, herbs, vitamins, or other supplements of any kind. I understand that failure to do so may affect my treatment outcome and increase the likelihood or severity of side effects or complications.

CONSENT TO TREATMENT

I understand and agree that I am consenting to receive a cosmetic treatment or service. This is strictly a voluntary cosmetic procedure. No treatment or service is necessary or required. The risks and complications associated with treatments or services and various alternatives have been explained to me by the Oregon Derma Center staff. I freely and voluntarily agree to undergo the treatment or service. I understand that the Oregon Derma Center services generally consist of a series of treatments and services to achieve maximum benefit and this consent shall apply to all services rendered to me by the Oregon Derma Center, including ongoing or intermittent treatments.

NO GUARANTEE

I UNDERSTAND THAT NO GUARANTEE HAS BEEN GIVEN AS TO THE RESULTS THAT MAY BE OBTAINED BY ANY OF THE SERVICES OR TREATMENTS OFFERED BY THE OREGON DERMA CENTER. Best efforts will be made to deliver excellent results and it is understood that patient compliance with recommendations is critical for optimal outcomes

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FINANCIAL RESPONSIBILITY FOR TREATMENT (please initial next to each line)

____ I understand that aesthetic treatments or services are not medically necessary, and are therefore not covered by any insurance or other third party payer program. I understand that I am fully responsible to pay for all of the services rendered to me.

____ In some instances, a pre-paid package of services may be purchased at a discount off of customary rates. As a condition of receipt of the discounted rate, I acknowledge and agree that packages of pre-paid services and treatments are non-refundable for any reason.

____ I understand that all services, including prepaid services, are non-refundable. I will not be entitled to a refund if I am not satisfied with the results of treatment, on account of a delay in treatment, if I relocate from the area, or for any other reason whatsoever.

____ I understand that if the procedure takes longer than the customary time, Oregon Derma Center reserves the right to charge an additional fee for each additional half hour.

X_____ Date: _____

SIGNATURE OF PATIENT OR PARENT IF MINOR OR RESPONSIBLE PARTY

Today's Date: _____

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SCHEDULING AND CANCELLATION

While Oregon Derma Center will strive to schedule and provide treatments during Oregon Derma Center's normal business hours and at such times as I may reasonably request, Oregon Derma Center cannot guarantee against delays in treatment due to scheduling conflicts for Oregon Derma Center personnel, maintenance to medical equipment, or any other foreseen or unforeseen causes.

If you cannot keep your appointment, please cancel as soon as possible. In order to assure our patients the highest level of service, we require a 48-hour cancellation notice. If such courtesy notice is not given, a $50 charge will apply for appointments with the medical aesthetician/assistant and $100 will apply for appointments with the doctor. All patients who do not give such notice will have to put a deposit toward their next appointment, which is forfeited if the "no show" recurs.

Failure to show for treatments that require an hour or more of staff time or special preparation will be charged at the full value. Failure to show or cancel 48 hours in advance for a treatment that is part of a package will result in forfeiting of that session.

Please plan on arriving about 10-minutes before your scheduled time to allow for unforeseen delays, such as traffic, parking or paperwork. Arriving 15-minutes or more late for an appointment may result in the need to reschedule or shorten your appointment time accordingly.

X_____ Date: _____

SIGNATURE OF PATIENT OR PARENT IF MINOR OR RESPONSIBLE PARTY

ACKNOWLEDGEMENT AND CONSENT TO TREATMENT (To be signed after the consult!)

I hereby acknowledge that I have read and understand all of the information presented to me before signing this acknowledgement and consent that the benefits and risks as well as the alternatives to the treatments or services have been fully explained to me and all questions that I might have about the treatments or services have been answered in a satisfactory manner. I hereby give unrestricted informed consent to receive the treatment and services. This acknowledgement and consent shall apply to all services rendered to me by the Oregon Derma Center staff, including ongoing or intermittent treatments.

I accept full financial responsibility for this treatment and all subsequent treatments. I further agree, in the event of non-payment, to bear the cost of collection, including court costs and attorneys' fees, should this ever be required.

BY SIGNING BELOW, I ACKNOWLEDGE THAT THE INFORMATION ON PAGES 1–7 HAS BEEN COMPLETED AND IS ACCURATE TO THE BEST OF MY KNOWLEDGE:

Print Patient name: _____

X_____ Date: _____

SIGNATURE OF PATIENT OR PARENT IF MINOR OR RESPONSIBLE PARTY

Today's Date: _____