Aesthetic MEDICINE
PHYSICIANS & SURGEONS
4800 SW Meadows rd, Suite 100
Lake Oswego, OR 97035
www.drdarm.com
Ph: 503.697.9777
Fax: 503.597.3708

TODAYS DATE:	WELLNESS CONSULTANT:

PATIENT INFORMATION

LAST NAME:	**FIRST NAME:**	**MI:**	**DOB:**	**AGE:**	SEX: M F

STREET ADDRESS	**CITY**	**STATE**	**ZIP**

HOME PHONE:	CELL PHONE:	WORK PHONE:

PRIMARY CONTACT NUMBER: (H) (C) (W)	MARITAL STATUS: S____ M____ W_____ D_____
OCCUPATION:	EMPLOYER:

EMERGENCY CONTACT:	RELATION:	PHONE:

E-MAIL ADDRESS:

WOULD YOU LIKE TO RECEIVE E-MAILED APPOINTMENT CONFIRMATIONS, PROMOTIONAL EVENTS, DISCOUNTS, AND SPECIALS FROM AESTHETIC MEDICINE? (Y)_____ (N)_____ . PLEASE NOTE: YOUR E-MAIL ADDRESS IS USED STRICTLY FOR OUR COMMUNICATION WITH YOU AND WILL NOT BE GIVEN OUT.

HOW DID YOU HEAR ABOUT US? DR DARM WEBSITE _____ INTERNET SEARCH _____ FLYER _____
COMMERCIAL (CHANNEL) _____ AM NORTHWEST _____ RADIO _____ PANDORA_____ FRIEND _____
WORD OF MOUTH _____ OTHER _____.

HEALTH INFORMATION

WHICH CONCERNS/ INTERESTS APPLY TO YOU? PLEASE NUMBER 1-3, WITH NUMBER 1 YOUR 1ST PRIORITY AND 3RD LAST.

Wrinkles		Botox		Dermal Filler		Unwanted Body Fat	
Brown Spots		Acne		Contouring		Cellulite/Stretch Marks	
Sun Damage		Scarring		Uneven Skin Tone		Muscle building/tone	
Rosacea		Facial Veins		Dark Circles		Urinary incontinence	

OTHER CONCERN(S): _____

MEDICAL HISTORY:	**YES**	**NO**
Have you had plastic surgery in the past?	☐	☐
Have you had liposuction procedures in the past?	☐	☐
Do you have allergies to any medications?	☐	☐
Are you pregnant or nursing?	☐	☐
Are you undergoing chemo/radiation therapy?	☐	☐
Have you tanned or used a self tanner in the last 2 weeks?	☐	☐

Please check any/all that apply:

_____ Diabetes _____ Bleeding Disorder ____HIV ____Phlebetis ____ Herpes Simplex

____ High Blood Pressure ____ Heart Problems ____ Auto Immune Deficiency

Please note any medications that you currently take:

_____

_____

Please indicate any medication/environmental/food allergies:

Allergies and reaction: _____

Do you take medications that prohibit sun exposure? If So, please name medication:_____

Please check if you have used any of the following during the time span indicated:

Accutane (6 mo)		Retin-A (2 wks)		Ibuprofen (3 days)	
Ginkgo (2 wks)		Fish oil (2 wks)		Aspirin (3 days)	
Vitamin E (2 wks)		Glycolic Acid (2 wks)		Anti-inflammatory (3 days)	

Please check one of the following skin types:

Type 1 – Burns and never tans		Type 4 – Never burns, always tans	
Type 2 – Always Burns, sometimes tans		Type 5 – Moderately pigmented (Hispanic, asian)	
Type 3 – Sometimes burns, always tans		Type 6 - Black	

Aesthetic Medicine wants to provide me with the utmost level of care. Thus, I am aware of the importance of disclosing my complete personal medical history. I will notify Aesthetic Medicine of changes in my health as they occur during my course of treatment. In addition, I will inform Aesthetic Medicine of all medications I am taking, including but not limited to: Prescription and over-the-counter drugs, herbs, supplements, vitamins, antibiotics and birth control. I understand any failure to do so on my part may result in an increase and likelihood of side effects or complications during and post treatment.

With my consent, Aesthetic Medicine may call, e-mail, text, leave a voice message or contact me directly in reference to any appointment reminders, specials, statements or as needed.

I understand and agree that no refund will be given for purchases made at Aesthetic Medicine on treatments, packages, services, gift certificates, or products. In-house credit only will be issued at management's discretion. I understand that if a package discount is offered and I elect not to complete my package, treatments received will revert to regular per-treatment pricing and I will forfeit any package discounts. In addition, I understand and agree that Aesthetic medicine reserves the right to refuse service to anyone, prior to, during or after treatments(s) without explanation or cause. I understand that all purchased packages are to be used within one calendar year of original purchase. Initial: _____

The American Medical Association states that a medical facility may charge for missed appointments - or for failing to cancel 24 hours in advance. I understand that upon the discretion of Aesthetic Medicine, a charge or fee may be applied for missed appointments, appointments canceled without giving 24-hour notice, or, appointment changed/rescheduled without 24 hours of the original scheduled appointment. Initial: _____

I understand that photographs are necessary to document, and track results and that Aesthetic Medicine may ask to photograph areas(s) being treated. Such photographs will be done using the utmost discretion and will never be released without my full knowledge and express written consent.

By signing this form, I am consenting to Aesthetic Medicine's use and disclosure of my protected health information. Additionally, my signature below indicates that I understand and agree with the above statements. If I do not sign this consent, Aesthetic Medicine may decline to provide treatment to me.

_____ _____/_____/_____

Patient Signature: **Date**

_____ _____/_____/_____

Witness Signature: **Date**