



6252 East Grant Road Suite 100

Tucson, AZ 85712 (520) 3COSMED (326-7633)

## Patient Registration Form

Patient's Full Legal Name: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Your Mailing Address: \_\_\_\_\_ Zip Code \_\_\_\_\_

Preferred Phone Number: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

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

Primary Care Physician: \_\_\_\_\_

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

Reason for Consultation: \_\_\_\_\_

Who should we thank for referring you? \_\_\_\_\_

Welcome, and thank you for choosing Oasis CosMedic Clinic. Please complete the following questionnaire. The answers you provide will better enable us to care for you and your aesthetic needs.

**Medical History:** Please circle the appropriate response.

- YES    NO    Heart Disease: Angina, High Blood Pressure, Murmur, Pacemaker, Poor Circulation
- YES    NO    Lung Disease: Asthma, Emphysema, Sleep Apnea
- YES    NO    Neurologic Disease: Stroke, Seizure
- YES    NO    Neuromuscular Disease: Multiple Sclerosis, Myasthenia Gravis
- YES    NO    Liver Disease
- YES    NO    Kidney Disease
- YES    NO    Diabetes or Hypoglycemia
- YES    NO    Thyroid Disease
- YES    NO    Gastrointestinal Disease
- YES    NO    Cancer
- YES    NO    Autoimmune Disease: Lupus, Rheumatoid Arthritis
- YES    NO    Bleeding Disorder or Blood Clots
- YES    NO    GYN Issues: Polycystic Ovarian Syndrome
- YES    NO    Pregnant or Breast Feeding
- YES    NO    Skin Disease: Psoriasis, Eczema, Rosacea, Erythema Ab Igne
- YES    NO    Infectious Disease: Herpes, Cold Sores, HIV/AIDS
- YES    NO    Tobacco, Alcohol, or Recreational Drug Use

CURRENT MEDICATIONS (Including herbs, vitamins, supplements, minerals, and homeopathic remedies)  
Include Name and Dosage:

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ALLERGIES (Please list all allergies including topical and oral medications, preparations, and foods):

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Are you allergic to Latex?      Yes      No

PREVIOUS SURGERIES AND PROCEDURES:

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Any problems with Anesthesia? (If yes, please explain):    Yes    No

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**AESTHETIC HISTORY**

LASER AND LIGHT BASED THERAPY (Please Circle the Appropriate Response):

- |     |    |   |
|-----|----|---|
| Yes | No | Previous Laser Hair Removal                                       |
| Yes | No | Recent Sun Exposure or Tanning                                    |
| Yes | No | Currently Using Self-Tanning Lotions or Treatments                |
| Yes | No | History of Hyperpigmentation (darkening of the skin) After Injury |
| Yes | No | History of Hypopigmentation (lightening of the skin) After Injury |
| Yes | No | Formation of Keloid scars (thick raised scarring) After Injury    |

What hair removal methods have you used in the past six weeks? (Please circle all that apply):

Shaving      Waxing      Electrolysis      Tweezing      Chemical Depilatories

Have you had previous laser skin therapy? (IPL-intense pulse light or Photofacial, radiofrequency, infrared, Thermage, or other modalities):      Yes      No

Skincare (Please Circle the Appropriate Response):

Have you ever used Accutane?    Yes    No

- If yes, when was your last dose? \_\_\_\_\_

Are you currently using any topical medications? (Including Retin-A or Tazorac): Yes      No

What products are you currently using? \_\_\_\_\_

Do you use sun protection (SPF, hats, etc.) on a daily basis? \_\_\_\_\_

Are you satisfied with your current skincare regimen? \_\_\_\_\_

Injectables (Please Circle the Appropriate Response):

Have you had previous BOTOX injections?      Yes      No

Have you had previous collagen or dermal filler injections?      Yes      No

Please Circle all services that you are interested in:

- |                       |                                 |
|-----------------------|---------------------------------|
| Dermal Fillers        | Skincare advice                 |
| Chemical Peels        | Skincare products               |
| Skin rejuvenation     | Sun damage/ age spot correction |
| Microdermabrasion     | Sclerotherapy                   |
| BOTOX Cosmetic        | Facials                         |
| Acne Treatment        | Hair removal                    |
| Make-up Application   | Skin Analysis                   |
| Waxing                | Eyelash Tinting                 |
| Spider Vein Injection |                                 |

Fitzpatrick Skin Classification (Please Circle Appropriate Response):

**Type I:** Always burns easily, never tans; extremely sun sensitive; red hair, freckles; Celtic, Irish or Scottish decent.

**Type II:** Always burns easily, tans minimally; very sensitive skin; fair hair, fair skin, blue eyes; Caucasian decent.

**Type III:** Sometimes burns, tans gradually; average skin.

**Type IV:** Burns minimally, always tans to moderate brown; minimally sun sensitive; Mediterranean, Caucasian, Asian decent.

**Type V:** Rarely burns, tans well; sun insensitive skin; Middle Eastern, some Hispanic, and some African American decent.

**Type VI:** Never burns, deeply pigmented; sun insensitive; African American decent.

**Thank you for your time!**

**Patient Signature:** \_\_\_\_\_

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

**Physician or Aesthetic/ Laser Technician Review:** \_\_\_\_\_



## PRIVACY PRACTICES

### Notice of Health Information Privacy Practices and Consent For Use & Disclosure of Health Information

The undersigned acknowledges Oasis CosMedic Clinic acts in compliance with the Health Insurance Portability and Accountability Act regarding patients' health information. Furthermore, a copy of the HIPAA notification shall be provided upon patient's request. By signing this form, patient consents to Oasis CosMedic Clinic's use and disclosure of protected health information in performing treatment, payment activities and healthcare operations.

Signature: \_\_\_\_\_

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

## PHOTOGRAPHIC CONSENT AGREEMENT AND RELEASE

The following agreement grants permission to Oasis CosMedic Clinic and its staff to photograph patient before, after and throughout the course of treatments. Oasis CosMedic Clinic agrees not to use patients name and fuji-face photos without patient's separate, express, written consent. Patient does hereby hold harmless Oasis CosMedic Clinic. its employees, and agents, now and forever, from any liability or claim from damages resulting from the above authorized use of said photographs.

Signature: \_\_\_\_\_

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

By initialing, patient consents to Oasis CosMedic Clinic's use of photographs of patient for the following purposes:

\_\_\_\_\_ Educational presentations and public lectures.

\_\_\_\_\_ Photographic portfolio of representative results to be shown to other patients of Oasis CosMedic Clinic.

\_\_\_\_\_ Promotional literature, public relations, educational materials and advertising materials in all media now, existing or to be invented in the future, including, but not limited to, books, magazines, newspapers, films, videos, television, the Internet and other media.



**OASIS COSMEDIC CLINIC  
TREATMENT CONSENT AND RELEASE**  
*PLEASE READ CAREFULLY AND SIGN BELOW*

I acknowledge that the practice of skin care and advanced medical aesthetic treatments including facials, chemical peels, microdermabrasion, intense pulsed light, laser hair removal, dermal injections for wrinkle correction, and various other beauty treatments are not an exact science, and no specific guaranties can or have been made concerning the expected results. I understand that some clients experience more change and improvement than others. In virtually all cases, multiple treatments are required in order to effect a satisfactory outcome.

I also realize that the following risks and hazards may occur in connection with any particular treatment, including but not limited to: unsatisfactory results, poor healing, discomfort, redness, blistering, nerve damage, scarring, infection, changes in skin pigmentation and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to hold harmless and release from any liability Dr. Kathleen P. Nichols, in her capacities as medical doctor and an officer of Oasis CosMedic clinic, as well as any other officers, medical directors, agents, employees, or successors in interest of Oasis CosMedic Clinic for any condition or result, known or unknown that may arise as a consequence of any treatment that I receive. I acknowledge that Oasis CosMedic Clinic does not offer refunds on treatments purchased.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\*Please note: Payment is due and payable at the time service is rendered.