columbia laser

skin center

PERSONALIZED SKIN ANALYSIS

Name:____Date:____________________________

All of us at Columbia Laser Skin Center are passionate about improving and maintaining healthy skin. Each of us have had our own personal skin care worries in the past, so we completely understand how overwhelming and intimidating this may seem to you. Our promise to you, is that we will be your partner on this journey to healthy skin. So that we can be the best partner possible, please take a moment to share with us your concerns.

What is the reason for your visit today?____

What additional concerns or services are you interested in? Please check all that apply.

_____Sun/Age Spots/Melasma	_____Fine Lines/Wrinkles	_____Rough Skin Texture	_____Scars
_____Unwanted Hair	_____Facial Veins/Redness	_____ Acne	_____Warts
_____Nasolabial/Smile Lines	_____Rosacea	_____Blotchy Skin	_____Nail Fungus
_____Frown Lines	_____Loose Skin of Face/Neck	_____Lash/Brow Tints	_____Leg Veins
_____Forehead Lines	_____Fuller Lips	_____Waxing	_____Skin Tags
_____Crows Feet	_____Marionette Lines	_____Longer Lashes	_____Facial Peels
_____Lips Lines	_____Microdermabrasion	_____Large Pores	_____Lose stubborn unwanted fat
_____Jowls/Turkey Neck/ Sagging Brows & Lids	_____Skin Care Products/Advice	_____Mineral Makeup	_____Double Chin

Please answer the following questions below by circling the appropriate number on a scale of 1 to 5 that best fits you.

When looking in the mirror, I am not concerned; somewhat concerned; or very concerned in the appearance of my skin or face.

Not Concerned **Somewhat Concerned** **Very Concerned**

1 2 3 4 5

When people look at me, they think that I look tired, angry, or sad.

Not Concerned **Somewhat Concerned** **Very Concerned**

1 2 3 4 5

I am concerned about the color, tone, and texture of my skin.

Not Concerned **Somewhat Concerned** **Very Concerned**

1 2 3 4 5

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First_______________________________ MI____ Last__________________________________
Address____
City/State/Zip____
Date of Birth________________Occupation____
E-mail____
(we do NOT share this with anyone and will use this information to send you our monthly newsletter)
Home Phone____________________________ Cell Phone_____________________________
Work Phone_____________________________ Other________________________________
Which number would you prefer we contact you for appointment reminders or other messages?
Home ___________ Cell ___________ Work ___________ Other ___________
In case of an emergency, we should contact:
Name ____ Phone _____________________
How did you hear about us?
_____ Friend/Family Member – Name ____
_____ Website
_____ Internet Search ____
_____ Newspaper – Which Paper? ____
_____Direct Mailer
_____ Radio
_____ Yellow Pages
_____ Brochure – Which Location? ____
_____ Salon/Spa____
_____ Movie Theater – Hood River _________ The Dalles _________
_____ Medical Provider/Facility ____
_____ Signage on Building/Walk-In ____
_____ Other ____
By my signature below, I acknowledge that the personal information I have given may be used for appointment reminders, voicemail messages, postcards, letters, electronic mail, and newsletters.
Client Signature ____ Date _____________

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Health History Questionnaire

General Health

______Severe or multiple allergies/anaphylaxis
______Recent immunizations/vaccinations
______History of herpes/fever blisters/cold sores
______Abnormal or irregular periods
______Abnormal hair growth to any part of body
______Bruise easily
______Bleeding disorder______________________
______History of blood clots or phlebitis
______Cancer______________________________

______Hepatitis
______Heart problems
______High blood pressure
______Diabetes
______Thyroid or metabolic disorders
______Polycystic Ovary Syndrome (PCOS)
______Rheumatoid Arthritis
______Lupus or autoimmune disease
______Neuromuscular Disease

_____Implants or implanted devices
(facial, dental, other)______________
_____Plastic surgery__________________
_____TummyTuck
_____Liposuction____________________
_____Porphyria
_____Lypomas or lypodema
_____HIV/AIDS

Skin

______History of skin cancer or melanoma
______Atypical/suspicious or changing moles
______Recurring/chronic skin infection/condition

______History of keloids or hypertrophic scars
______Vitiligo (skin whitening disease)
______Sensitive skin

_____Rosacea
_____Acne
_____Excessively dry skin

Have you recently used any products to exfoliate your skin?

_____Alpha/Beta Hydroxy Acids
(glycolic, lactic, salicylic)

______Enzyme Peels

_____Scrubs

Lifestyle

______Drink red wine
______Extensive dental work (past/upcoming)

______Pluck, wax or shave facial hair
______Use bleaching creams
or dipilatories for facial hair

_____Smoke cigarettes/tobacco use
_____Tattoos or permanent makeup

Sun Exposure

______Frequent tanning (past or present)
______Use of tanning beds (past or present)

______Suntan or tanning bed exposure in past 2 weeks
______Use of self-tanner or spray-on tan in past 2 weeks

Do you use sunscreen daily? ______yes ______no

Are you planning above normal sun exposure? ______yes ______no

Pregnancy

Some of our services may not be safe during pregnancy, when attempting to become pregnant or if breastfeeding. Please advise us if any of these apply to you now or at some point in the future.

______I am pregnant

______I am attempting to become pregnant

_____I am breastfeeding

Medications/Supplements/Over-the Counter Medications

For your safety, it is IMPORTANT that you list ALL medications, over-the counter medications and supplements/vitamins that you are currently taking. Some of these may interact with your treatment possibly causing complications. Are you currently taking/using or have you taken in the last 2 weeks any of the following?:

______Aspirin

______Anti-inflammatories (Ibuprofen, Aleve, Motrin, etc.)

______Fish Oil

______Red Wine

______ Anticoagulant (Coumadin, Warfarin, Plavix, etc)

______ Retin-A, Renova, retinol, Differin, Tazorac, tretinoin

______ Accutane

______ Medications containing gold

List ALL medications, supplements, vitamins and over-the counter products below and update at each visit:

Prescription Medications	Supplements/Vitamins	Over-the-Counter Products

Allergies

Medication allergies (please list):______________________________

Are you allergic to lidocaine or any medication used for numbing are anesthesia? ______yes ______no

Are you allergic to any cosmetics or skin care products? If so, please list______________________________

Do you have any environmental allergies? If so, please list______________________________

Are you allergic to porphyrins? ______yes ______no

Please Answer the Following Questions

Describe your skin:

______Very fair, always burn never tans

______Light, burns easily, rarely tans

______Sometimes burns, slowly tans

______Burns minimally, always tans

______Tans well, rarely burns

______Tan, never burns

Do you have any background of the following: Indian, Native American, Mediterranean, Persian, Asian, African, Alaskan Native, or Latin American? Accurate determination of your skin type is important for planning your treatment and to obtain safe and optimal results.

______yes ______no

Please list the skin care products that you use daily

Cleanser______________________ Serums______________________ Eye Cream______________________

Toner______________________ Moisturizer______________________ Sunscreen______________________

Name______________________________ Date______________________

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APPOINTMENT CANCELLATION / NO SHOW POLICY
As a courtesy to those clients waiting for appointments and our staff, we require notification of rescheduling your appointment within one full business day before your scheduled appointment. If you fail to make your appointment or do not reschedule your appointment you will be charged a $75 No Show Fee which is non-refundable.

All appointments must be secured via a credit card.

For the following spa appointments –
- Waxing services
- Brow & Lash Tint
- Lash Perm
- Dermaplaning
- Massage Services
- Makeup Services

The appointment must be rescheduled within one business day of the scheduled appointment. If you fail to make your appointment or do not reschedule your appointment you will be charged the cost of the service you were scheduled for.

PAYMENT POLICY
Fees for all services are paid in full at the time of service. We accept Visa, MasterCard, Discover, American Express, debit cards, checks, and cash. Any check returned for insufficient funds will be assessed a fee of $25.00. Patient financing is available through Care Credit. We do not offer any refunds on services rendered. Unused balances on treatment packages will not be refunded. However, those balances can be applied to other services and products offered by Columbia Laser Skin Center.

Any fees discussed during a consultation are general estimates. You will be given an individualized treatment plan with fees, which are valid for a period of ninety (90) days after the consultation appointment.

Since most of our procedures are considered cosmetic and not deemed medically necessary, we do not bill insurance.

GUARANTEES
Because individual results vary, the staff of Columbia Laser Skin Center cannot guarantee those results. Nor can the staff precisely estimate the actual number of treatments required for optimal results.

Signature ____ Date _____________

Columbia laser skin center

Patient Consent for Medical Photography

Patient Name ____ DOB _______________

I consent for medical photographs to be made of me at Columbia Laser Skin Center, LLC. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact Dr. John Willer and/or the licensed medical staff of Columbia Laser Skin Center, LLC.

By signing this form below, I confirm that this consent form has been explained to me in terms that I understand.

I consent for these photographs to be used in office publications, including our website, newsletter, or office literature. I understand that members of the general public may see the images. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

Signature ____ Date ______________

I agree to use my image for medical records **ONLY:**

Signature ____ Date ______________

For patients between ages 7 and 18 years, a signature below indicates that the information in this consent form has been explained to me and I assent to use of my images as outlined above.

Signature ____ Date ______________
Parent or Legal Guardian

Columbia Laser Skin Center

Acknowledgment of Receipt
of Privacy Practices

Client Name ____Date of Birth ____________

I acknowledge that I have received the Privacy Practices Notice of
Columbia Laser Skin Center

Client Signature____ Date _______________

I consent to receive marketing material from Columbia Laser Skin Center containing information on promotions, specials, new procedures & products. This material may come via email, mail, fax and/or phone

Client Signature____Date_________________

If client is under the age of 18

Parent/Guardian Name ____

Parent/Guardian Signature ____

Relationship to Client ____

Date ___________