Patient Registration Form

Last Name:______________________ First Name: ____________________ MI:____

Date of Birth: ____________ Age:____________

Address:____

City:_____________________ State:_________________ Zip Code:_____________

Home Phone __________________ Cell Phone ___________________

Emergency Contact _____________________________ Phone _________________

Who May We Thank For Referring You____________________________________

______(initial) I certify that I understand the privacy risks of the mail, phone calls, e-mail and text messaging. I authorize Alchemy Aesthetic Institute at VIRGINIAdermatology & skin cancer center or its' affiliates to send marketing promotions and/or appointment reminders via electronic communication or mobile devices. I understand I have the right to rescind this consent at any time by notifying Alchemy Aesthetic Institute at VIRGINIAdermatology & skin cancer center or its' agent in writing.

The e-mail address approved for use:_______________________________________

Medical History

Please complete the following information so that we may better serve you. All information will be kept confidential.

Primary Care Physician Name & Address:

____

Please list any Allergies to food, drugs, latex, and sulfur______________________

____

Are you currently under the care of a dermatologist (within 1 Year)? If yes please list:

____

Indicate the medications you have used or are using on your skin:

____ Renova ____ Bleaching Agents ____ Benzoyl Peroxide ____ Accutane

____Hydroquinone ____ Retin-A ____Steroid Cream ____ Antibiotic ____Other_________

List **all medications** you are currently taking. Please include aspirin, blood thinners, all over the counter medications and recent antibiotic use.

Medication	Dose	Frequency
______________	______________	______________
______________	______________	______________
______________	______________	______________

Do you have any of the medical conditions or a family history of the following?

Yes No Pregnant or currently breastfeeding? ______________________________

Yes No Postmenopausal or hysterectomy?_________________________________

Yes No Cancer? Location and type: ____________________________________

Yes No Sensitivity to skin care products? Please list___________________________

Yes No Stroke, Seizure, Migraines?___________________________________

Yes No High blood pressure, cardiac disease, implanted pacemaker or defibrillator.

Yes No Do you smoke? Packs per day _____x _____ years- Quit when______________
Yes No Kidney stones or renal failure?___________________________________

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Yes No Hepatitis, liver problems, or jaundice?________________________________

Yes No Diabetes? Diet or insulin controlled__________________________________

Yes No Bleeding disorders, Blood clots, hemophilia, or sickle cell? _______________

Yes No Musculoskeletal problems, joint disorders? ____________________________

Yes No Gastrointestinal disorders, hernia, ulcers, indigestion?____________________

Yes No Herpes or cold sores, HIV +, or other infectious disease_________________

Other medical history, complications, or recent surgeries_________________________

Skincare Assessment

What concerns you most about your skin? **Circle all that apply**:

Loss of Firmness	Breakout	Sensitivity	Hair Reduction
Dryness/ Dehydrated	Flakiness	Skin Discoloration	Oil Control
Expression Lines	Spider Veins	Sun Damage	Rosacea
Enlarged Pores	Wrinkles	Broken Capillaries	Dullness

Other_______________

How would you like to improve the condition of your skin? ______________________

____

What areas do you want to treat? Face Neck Chest Hands Lower Body

*Circle your ethnic background: White Black Hispanic Asian Other_________

***ethnicity required for laser treatment protocols**

Please mark with an X all that apply to your skin, skincare regimen or daily routine.

	Oily - Oily T-Zone, Chin and Cheeks		Dry - Non-Oily Skin Tightness
	Combination - Oily T-zone, Cheek area slightly dry		Acne – Blackheads, whiteheads, pimples
	Cleanser		Toner
	Facial Scrub		Moisturizer
	Sunscreen		Sunblock SPF 30 or more

Do you do participate in any of the following?

_____Aerobic Activities _____Sports ____Outdoor Activities

Daily Consumption of:

Water ____oz. Coffee ____oz. Alcohol_____ oz. Soft Drinks ____oz.

I acknowledge that the above information is true and correct to the best of my knowledge.

Patient Print:_______________________________________

Patient Signature: ________________________________ **Date:** ____________________

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Treatment and Service Policies

Thank you for choosing Alchemy Aesthetic Institute at VIRGINIAdermatology & Skin Cancer Center we aim to provide outstanding service to you. In order to administer the highest level of care we use an appointment system that gives us ample time with each client. If a situation arises that results in you being unable to keep your appointment we ask that you give us a 48 hour notice. If we do not get that notice we are unable to use that time, therefore, it is time lost to our Practice.

With that in mind we have implemented the following cancellation policy:
A 48 hour notice is required for all cancelled appointments, excluding emergencies. If this notice is not provided a $50 NO SHOW fee will be charged.
In order to implement this policy effectively we will require a credit/debit card or other payment method when scheduling an appointment for all injectable and aesthetic services.

We ask patients to arrive 10 minutes before their scheduled appointment time, patients arriving more than 20 minutes late may be required to reschedule their appointment.

I understand that this treatment is a Cosmetic Treatment and that no medical claims are expressed or implied.

I further understand that to achieve maximum and continued results, the recommended protocol should be followed.

By signing below you acknowledge that you have been informed of this policy, and agree to adhere to it.

Patient Name (print) ____________________________

Patient Signature ________________________________

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Request and Consent to Photography and/or Video Record

Your provider may need to photograph and/or record you to document a medical condition, help with diagnosis and/or treatment of a condition, and/or to help plan the details of a treatment. Photographs and/or recordings taken for these clinical reasons do not require your written permission. Your provider does need your written permission to use your photographs and/or recordings for the non-clinical reasons below.

I hereby authorize Alchemy Aesthetic Institute, including the attending doctor or other designated person(s), to photograph and/or video me for the following purposes: Check **YES** or **NO**.

1. For the advancement of **not-for-profit** medical purposes, including teaching, research, and education. I understand that education is an important part of Alchemy Aesthetic Institute's commitment to teaching healthcare providers.
   YES ☐ **NO** ☐

2. To show or release to current or future Alchemy Aesthetic Institute patients for the purpose of education and consultation. I understand these photos or videos can be taken at any time during my treatment which includes pre-treatment, post-treatment, pre-operative, intra-operative, post-operative photos, and/or videos of my treatment, surgery and/or procedure.
   YES ☐ **NO** ☐

3. For **external not-for-profit** educational purposes outside Alchemy Aesthetic Institute such as lectures, presentations at professional conferences, news publications, website publications, social media posts, and email blasts.
   YES ☐ **NO** ☐

I consent to photographs and/or video recordings under the following conditions:

- Copies of the photos, videos, and/or films may be released to me if I ask for them.
- I can refuse to have photos and/or video taken without any change in my patient care at Alchemy Aesthetic Institute.
- I understand and agree that although my name will not be used, it may be possible to identify me from a photo and/or video.
- I understand that once released outside of Alchemy Aesthetic Institute, Alchemy Aesthetic Institute does not have control over the photos or videos.

Revoking Permission: This authorization has no expiration date; however I may revoke it at any time by writing to Alchemy Aesthetic Institute at the address below. I must state in writing that I no longer give consent for photo(s) and/or video(s) or for the use of any photo(s) or video(s) that were already taken.

I have read and understand the information. I hereby release Alchemy Aesthetic Institute, its personnel, and any other persons participating in my care from any and all liability which may or could arise from the taking

____   ______/______/________
Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign)   Date (mm/dd/yyyy)

____
Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)
Relationship ☐ Spouse ☐ Parent ☐ Next of Kin ☐ Legal Guardian ☐ DPOA for Healthcare

____   ______/______/________
Consent Obtained, Explained and Witnessed By   Date (mm/dd/yyy)

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