FOR OFFICE USE ONLY

☐ Verju	☐ Zerona	☐ EndyMed Face	☐ EndyMed Body	☐ Photofacial	☐ PerfectDerma	☐ Skin Consult
☐ W-H-T		☐ Under eye	☐ Tummy	☐ Face		
☐ Tummy		☐ Jaw line	☐ Love Handles	☐ Chest	Price: ____________________	
☐ Hip/Thigh		☐ Neck	☐ Banana		Deposit: __________________	
			☐ Back Thighs		Credits: __________________	
			☐ Other: ________		Curva: Y N	

Patient Information

Name: ________________________________ **DOB:** ______________________ **Today's Date:**________________

Address:______________________________ **City:** _______________________ **State:** ______ **Zip:** _________

Phone: ____________________ **Email:** ____

Additional Information

How did you hear about us? TV Commercial Destin Log NWF Daily News Facebook Other: ________

Are you concerned with any of the following?

Acne Wrinkles Skin Sagging Eye Creases Jowls Neck Sagging Skin Crepiness Pore Congestion Skin Dryness

Skin Oiliness Brown Spots on Face Brown Spots on Body Cellulite Belly Fat Thighs Buns Weight

What are your Top 3 concerns above or otherwise:

1) ________________________ 2) ________________________ 3) ________________________

***Females*: Are you pregnant, nursing or planning on becoming pregnant soon?** Yes No

When was your last menstrual cycle? ___________________

Do you have or do you experince any of the following?

Pacemaker Thyroid Condition Cardiovascular Condition Ulcers Gout Muscular Lymphatic or Bleeding Disorders

Electrical Device Implant Liver or Kidney Disease (PCOS) Polycystic Ovarian Syndrome Seizures Hepatitis

Form Keloids Acne Problems Cold Sores Herpes

Do you have or have you ever had cancer? Yes No If Yes, when________________

Have you had radiationtherapy in the past 6 months? Yes No If Yes, when________________

Please list ALL surgeries that you have had and the years performed. ________________________________

____

Please list ANY prescription or over the counter medication (including vitamins) that you are taking and what you take them for

____

____

Do any of your medications make you light sentitive? Yes No If Yes, what ______________________

Are you under Any doctor's care for any health conditions currently? ________________________________

Acknowledgement of Privacy Practice
** You May Refuse to Sign This Acknowledgement***

I, _________________________________, have received a copy of this office's Privacy Policy.
Name of Patient

______________________________ ______________
Signature of Patient/Parent/Guardian Date

Authorization to Release/Discuss Information

I, _________________________________, being of legal age, give Shawna Hogan, D.C. authorization to release and discuss my health and dental information with the person/persons listed below.

____ Parents Name(s) ____________________ Home # ________ Cell # ________ Work # ____________

____ Spouse Name ______________________ Home # ________ Cell # ________ Work # ____________

____ Other Name(s) ____________________ Home # ________ Cell # ________ Work # ____________

This authorization will stay in effect unless I request that it be changed.

____ _____________________
Signature Date