Derek F. Norcom, MD
Janice Buenafe, MD
Yan Duan, FNP

7180 SW Hazelfern Rd
Tigard, OR 97224
503-772-3297

Patient Name ________________________________ DOB______________ Today's date ______________

Address _____________________________________ City ________________ State _____ Zip __________

Home (______) ____________Cell (______) ___________________Work (______) ____________________

Primary contact number? (H) (C) (W) Sex: M ___ F___ Marital Status: S ___ M ___ W ___ D ___

Occupation _____________________________ Employer ________________________________________

Emergency Contact ____________________________Relation___________ Phone (_____) _____________

Email Address: ____________________________________________________________________

***Would you like to receive future monthly emails for promotional events, discounts, and specials from Bridgeport Laser & Wellness Center? (Y) __ (N)___ Please Note: Your email address is used strictly for our communication with you and will not be given out.***

***How did you hear about us?*** Website/Internet ____ Newspaper ____ Billboard ____ TV Commercial ______

Radio ___ Friend ___(*name) _________________________Other (please specify) _____________________

**A $25 credit is added to your account for each friend or family member you refer to our practice.*

## HEALTH INFORMATION

***Which concerns apply to you? Please circle all that apply.***

| | | | |
|---|---|---|---|
| Black or Whiteheads | Brown spots (hyperpigmentation) | Cellulite | Clogged pores |
| Dry patches | Enlarged pores | Excessive oiliness | Scarring |
| Skin laxity | Spider veins | Stretch marks | Upper lip lines |
| Unwanted body fat | Unwanted hair | Uneven skin tone | Varicose Veins |
| Visible exposed blood vessels | | White spots (hypopigmentation) | Wrinkles |

Other: ___________________________________________________________________________

Are you pregnant or trying to become pregnant?__________ Do you use oral contraceptives? _____________

Are you allergic to any cosmetic ingredients or foods? (Y) __ (N) __ If yes, please list:

_____________________________________________________________________________________

_____________________________________________________________________________________

Do you have any neuromuscular or autoimmune diseases? (Y) __ (N) __ List: ___________________________

_____________________________________________________________________________________

Do you have allergies to latex? (Y) ____ (N) ____ Do you have a fear of needles? (Y) ____ (N) ____

Do you smoke? (Y)____ (N) ____ If yes, how many per day ______________ How many years ____________________

Do you drink alcohol? (Y) ____ (N) ____ If yes, how much ________________ How often ________________________

Do you take Aspirin, Advil, Motrin, Ibuprofen, or anti-inflammatory meds more than once a week? (Y) __ (N) __ If yes, please explain: ____________________________________________________________

List all medications you are taking (prescription and over the counter): ______________________________
____________________________________________________________
____________________________________________________________

Do you have any allergies to medications? (Y) ___ (N)____ If yes, please specify and state type of reactions:
____________________________________________________________

Do you take oral anti-coagulant (blood thinning) medication? (Y) __ (N) __ Specify: ______________________

Have you had any cosmetic procedures in the past? Please list: ______________________________
____________________________________________________________

Please list all surgeries or hospitalizations with dates: ______________________________
____________________________________________________________

***Have you ever had any of the following (please circle):***

| | | | | |
|---|---|---|---|---|
| Asthma | Arthritis | Anemia | Autoimmune disorder | Blood disorder |
| Chest pain | Clotting disorder | Diabetes | Depression | Easy bruisability |
| Excessive scarring | Excessive bleeding | Heart attack | Heart valve disease | Heart failure |
| Heart valve replacement | Hepatitis | High blood pressure | HIV | Hormonal problems |
| Irregular heart beat | Intestinal problems | Impaired circulation | Impaired skin sensation | Keloids (scars) |
| Kidney disease | Liver disease | Lung disease | Multiple Sclerosis | Muscular dystrophy |
| MVP (heart valve problem) | Migraines | Open Infected wound | Paroxysmal cold hemoglobinuria | |
| Pregnancy | Raynaud's disease | Rheumatic fever | Seizures | Shortness of breath |
| Skin cancer | Stomach problems | Stroke | Thyroid disorder | |

Cancer: (Please list type) ____________________________________________________________

## Please complete this section if you are interested in:
## SMARTLIPO / ACCENT RF

Age: _______ Current Weight: ___________lbs Height: __________ ***OFFICE USE – BMI***: _____________

Is your general health good? Yes ____ No ____ Date of last physical ______________________

Name of family physician ____________________________________________________

What attracted you most to learning about Smartlipo / Accent RF? ______________________________
____________________________________________________________

What problem area(s) are you considering having treated? (Please circle area or areas)

| | | | |
|---|---|---|---|
| Abdomen | Inner Thighs | Arms | Neck / Face |
| Flanks (Muffin Top) | Outer Thighs | Upper Back (Bra Area) | Male Chest |

***PATIENT'S SIGNATURE:***

To the best of my knowledge, the information provided above is true and accurate.

Patient Signature ____________________________________________Date________________

Provider Signature____________________________________________Date________________

## Please complete this section if you are interested in: INJECTIBLES / LASERS / SKIN CARE

What is your skin type: Dry ______ Oily _______ Normal ______ Combination ______

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation: Please list: ____________________________________________

____________________________________________

____________________________________________

Have you ever had any of the following Injectibles or implants: (please circle)

Botox Juvederm Radiesse Perlane Silicone Collagen Hylaform

Lipo Dissolve Other: ____________________________________________

If so, when was it done ____________________________ What area(s) ________________________

Please check the products you currently use and list the BRAND NAMES (if possible) of Cosmetic Products:

Cleanser ______________________________________
Moisturizer ____________________________________
Toner _________________________________________
Mask __________________________________________
Astringent _____________________________________
Salicylic Wash/Cleanser__________________________
Vitamin A Cream ________________________________
Soap __________________________________________
Night Cream ____________________________________
Eye Cream _____________________________________
Glycolic Wash/Cleanser ___________________________
Scrub _________________________________________
Sunscreen ______________________________________
Vitamin C Creams ________________________________
Alpha or Beta Hydroxy Cream ______________________________________________

Do you have any of the following chronic skin disorders?

Psoriasis _____ Dermatitis _____ Eczema _____ Keloid Scarring ____
Cold Sores ____ Sun Blisters ____ Fever Blisters ____ Herpes Simplex/Blisters ____

Have you ever undergone any of the following treatments?

Microdermabrasion ____ Acid Peel ___ Cosmetic Surgery ___ Accutane ___

Are you currently removing hair by any of the following methods?

Laser Hair Removal_____ Waxing___ Tweezing____ Nair type products____ Electrolysis____

If so, when was it done? ________________________ What area(s)___________________________

What type of laser equipment was used? ____________________________________________

***PATIENT'S SIGNATURE:***

To the best of my knowledge, the information provided above is true and accurate.

Patient Signature ____________________________________________ Date_________________

Provider Signature___________________________________________Date_________________

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Bridgeport Laser & Wellness Center** may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I understand that **Bridgeport Laser & Wellness Center** will retain my records for three full years after treatments cease. During this time, all personnel at **Bridgeport Laser & Wellness Center** will have complete access to my records. However, no third party shall receive copies of my records without my specific written consent.

**Bridgeport Laser & Wellness Center** 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 **Bridgeport Laser & Wellness Center** of changes in my healthcare as they occur during my treatment process. In addition, I will inform **Bridgeport Laser & Wellness Center** 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 in the likelihood of side effects of complications during and post treatment.

With my consent, **Bridgeport Laser & Wellness Center** may call or email my home or other designated location and leave a message on voice mail or with me directly in reference to any items that assist the practice in carrying out TPO. I also consent to receive via mail or email items such as appointment reminders and/or patient statements or any forms that are requested by patient and/or practice. I have the right to request that **Bridgeport Laser & Wellness Center** restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand and agree that no refund will be given for purchases made at **Bridgeport Laser & Wellness Center** 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 **Bridgeport Laser & Wellness Center** reserves the right to refuse service to anyone prior to, during or after treatment(s) without explanation or cause.

I understand that photographs are necessary to document and track results and that **Bridgeport Laser & Wellness Center** may ask to photograph the area(s) being treated. Such photographs will be done using the utmost discretion and will never be released with out my full knowledge and expressed written consent. ______ *By initialing here, I consent to the discretionary use of my photos for before & after reference as needed.*

By signing this form, I am consenting to **Bridgeport Laser & Wellness Center's** use and disclosure of my PHI to carry out TPO. Additionally, my signature below indicates that I understand and agree with the above statements. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Bridgeport Laser & Wellness Center** may decline to provide treatment to me.

______________________________ ______________________________
Patient's Signature Date

______________________________
Please Print Your Name

______________________________ ______________________________
Provider's Signature Date

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## *No-Show and Cancellation Policy*

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointments with Bridgeport Laser & Wellness Center are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to decrease unnecessary costs and to contain our fees, we maintain a **No Show/Cancellation Policy** for all our patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or unable to be kept must be cancelled more than 24 hours in advance. Cancellations must be made between 10 a.m. and 6 p.m. on workdays at least one full business day before the scheduled appointment. Cancellations must be done over the telephone by speaking directly to one of our scheduling professionals. Patients will not be charged for an office visit if cancellation is made 24 business hours before their appointment.

In the event an appointment is missed or cancelled with less than 24 hours' notice or no notice, a $75 charge will be billed. If a second no-show or same day cancellation occurs, we reserve the right to terminate the patient-doctor relationship. This policy is in effect for all appointments at our office, including clinical and cosmetic appointments. Again, all no-shows or same-day cancellations will be charged $75 if not cancelled with a 24 business hour notification.

Finally, we advise you to review this agreement with the counsel of your choosing and by signing this agreement you acknowledge that you have had an opportunity to review this agreement with counsel of your choice if you desire to do so. This agreement shall be valid and enforceable for five years from Bridgeport Laser & Wellness Center's last date of service to you. Bridgeport Laser & Wellness Center reserves the right to modify any policies without notice.

**My signature below indicates that I have read and understand these policies.**

*X* ______________________________________ ______________________

**Patient or Responsible Party Signature** **Today's Date**

______________________________________

**Please Print Name**

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## *Credit Card Charge Authorization Agreement*

**Bridgeport Laser & Wellness Center** must have a current credit card on file to secure appointments. This policy is in effect for all appointments at our office, including clinical and cosmetic.

**I, ____________________________________________________________, the holder of**

**(Please circle one):   VISA   MASTERCARD   DISCOVER   AMEX**

**Card Number ____________________________________ Exp______/______ CCV/Auth#______**

hereby authorize Bridgeport Laser & Wellness Center to charge my credit card in the amount required in the **No Show and Cancellation Policy**.

I have read the entire **No Show and Cancellation Policy** agreement and understand that I will be held fully responsible for its terms and charges. I agree not to chargeback Bridgeport Laser & Wellness Center, as long as I receive the services agreed upon by consent verbally or written and office guidelines are followed for my rescheduling and cancellation of appointments.

Name on Card: __________________________________________________________

Signature: ______________________________________________________________

Credit Card Billing Address: _______________________________________________

City, State, and Zip: _______________________________________________________

Telephone: (____) _______________________________

Date:___________________________________________