



**Patient's Personal Information**

Name: \_\_\_\_\_ Date \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street Apt. # City State Zip

Date of Birth: \_\_\_\_\_ Sex:  Male  Female

E-Mail Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Employer: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

**Referral Information** Referred by: \_\_\_\_\_ May we thank him or her? Y N  
 Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Emergency Contact** Name of person to contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Other #: \_\_\_\_\_

**HIPAA Information**

I hereby request the use of the following confidential communication channels when communicating information related to my personal health or treatment. This request supercedes any prior request for confidential communication channels I have made.

Which telephone number(s) may we use to contact you? Home Work Cell

May we discuss pertinent information with anyone else? Yes No

If yes, please state their name and relationship to you.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**What treatments are you interested in? (check all that apply)**

- BODY ENHANCEMENT
  - Botox for excessive sweating
  - Radiesse for hands
  - Liposuction with SmartLipo
- EXFOLIATION/PEELS
  - Cosmelan  Microdermabrasion
  - Dermaplaning  MicroPeel
  - LHA Peel  Obagi Blue Peel
- FACIAL ENHANCEMENT
  - Botox  Radiesse
  - Juvederm  Restylane
  - Perlane  Sculptra
- HAIR REMOVAL
  - Laser hair reduction
  - Waxing
- PIGMENTATION/AGE SPOTS
  - XPL (PhotoFacial)
  - Laser pigmented lesion removal
- REDNESS/ROSACEA
  - LaserFACIAL
- SKIN TIGHTENING
  - Fractional laser resurfacing
- VEIN REMOVAL
  - Sclerotherapy
  - Laser vascular lesion removal
- OTHER
  - Facials
  - Makeup Instruction/Application
  - Permanent Makeup
  - Visia Skin Analysis
  - \_\_\_\_\_

**Financial Information**

*I understand that I am financially responsible for all charges. I understand that office visit charges are payable on the day service is rendered. KO'AN Center is not responsible for billing my insurance company. I am aware of a 24 hour cancellation policy for all appointments, and I will be charged a specified amount for the service scheduled.*

\_\_\_\_\_  
 Date Signature of Patient or Guardian