

Confidential Client Information

Client Name: _____ Date: _____
Address: _____ Apt: _____
City, State _____ Zip: _____
Email*: _____

*By providing your email address you are agreeing to communication via email.

Home Phone (primary) _____ Work Phone (primary) _____ Cell Phone (primary) _____

Date of Birth: _____ Age: _____ Sex: Male Female

How did you hear about us? (Please circle one)

Facebook Google Bing Yahoo Other Internet Search _____ TV/Infomercial Magazine
Radio (Station?) _____ Billboards Current Client _____ Other _____

Current Medications:	Dose	Number of Pills	How Often	For What
Example: <i>Calcium</i>	<i>500 mg</i>	<i>1</i>	<i>2 times a day</i>	<i>Bones</i>
1.				
2.				
3.				
4.				

Allergies: Medications or substances	Symptoms/Reactions
1.	
2.	
3.	
4.	

Consent to Treat

I, the undersigned, hereby voluntarily consent and grant permission to DaVinci Body Sculpting and clinicians to perform treatments as indicated at DaVinci Body Sculpting for myself or the above named minor, for as long as I am a client at DaVinci Body Sculpting.

Signature of Client or Personal Representative Date

Consent to Photographs

I consent to photographs being taken for medical and diagnostic purposes. I understand these photos will not be used for any advertising and/or marketing purposes without my further written consent.

Signature of Client or Personal Representative Date

Acknowledgement of Review of HIPAA/Notice of Privacy Practices and client Rights

I have reviewed this office's HIPAA/Notice of Privacy Practices and client Rights. I understand that I am entitled to receive a copy of this document.

Signature of Client or Personal Representative Date