ADC Medical Spa Patient Information

Angelina Papaioannou BSN, RN & Alyssa Lannon BSN, RN

Book an appointment #508-285-8301

PATIENT'S NAME _____SEX_____

BIRTH DATE_____/____/_____ PREFERRED PHONE _____

PRIMARY ADDRESS (STREET) _____

CITY _____ STATE _____ ZIP_____

EMAIL ADDRESS_____

WHAT ARE YOUR AREAS OF CONCERN?

_____

_____

_____

CURRENT MEDICATIONS _____

RECENT PROCEDURES/INJURIES _____

ALLERGIES _____

MEDICAL HISTORY (LIST ALL CONDITIONS/CONCERNS)

_____

_____

_____

PHOTOGRAPH DISCLOSURE: Our providers take photographs prior to, as well as after treatments are complete. These photographs are used to aid in tracking our client's outcomes and progression of our client's goals.

Upon signing this consent, I hereby verify that I have disclosed any and all medical conditions and treatment goals with my provider. This consent establishes that any information shared with the provider remains strictly confidential between the client and provider. The contexts of these records may not disclosed without the consent of the individual client. The client may request a copy of their consent form upon request.

SIGNATURE:_____DATE:_____