TWIN PORTS
Dermatology

ADVERSE EVENT REPORT

-PLEASE PRINT & FILL OUT THE FORM COMPLETELY-

PATIENT INFORMATION

First Name:		Last Name:	Middle Initial:
Prefers to be called:		Ethnic Background:	Birth Date: / /
Pronouns ☐ He/him ☐ She/her ☐ They/them	Gender:	Occupation:	
	Phone #: ( )	Email:	
	Emergency Contact Name:	Emergency Contact Phone #: ( )	
Street Address:			P.O. Box:
City:		State:	ZIP Code:

PRODUCT & REACTION DESCRIPTION

Product Name:	Lot #:	Expiration Date: / /
Where was this product purchased? ☐ Online ☐ In-clinic	Start Date: / /	End Date: / /

Please describe your adverse skin reaction: _____

SIGNATURES

Initials: _____ I have read Twin Ports Dermatology's HIPAA Acknowledgement Form.

Initials: _____ I have read Twin Ports Dermatology's Notice of Privacy Practices. I know I can ask for a copy at any time.

Initials: _____ I understand cosmetic treatment results vary and are not guaranteed.

Initials: _____ I understand refunds are not issued for the cosmetic service(s) performed.

Initials: _____ I understand refunds on retail product must be returned within 30 days of purchase for an exchange or Med Spa credit only. If a product is returned after 30 days of purchase due to an adverse reaction, a full refund will be given as Med Spa credit only. There are no cash refunds.

Initials: _____ I understand all Skin Medica, Vivier, IS Clinical, and Colorescience products are final sale and no returns or exchanges are accepted.

The above information is true to the best of my knowledge.

Patient/Guardian Signature: _____ ***Date:*** _____