New Patient Information

Name: _____ Birth Date: _____/_____/_____
Age:____
Address: _____ Sex: M / F
City: _____ State:_____ Zip Code:_____
Home: (____) _____ Work: (____) _____ Cell: (____) _____
E-mail: _____
Emergency Contact: _____ Telephone: (_____)_____
Allergies: _____
How did you hear about our Laser Services? _____
_____
_____

Please put a check mark next to the procedures about which you would like to receive more information:

___ Acne Treatment
___ Botox to Flatten and Prevent Wrinkles
___ Enhanced Skin Rejuvenation
___ Collagen Augmentation
___ Wrinkles
___ Skin Toning or Pore Size Reduction
___ Facial Redness
___ Brown Spots
___ Sun Damage
___ Broken Capillaries
___ Spider Veins/Leg Veins
___ Hair Removal
___ Shaving bumps/ingrown hair

Please put a check mark next to a past or current medical condition:
Medical History:

___ Lupus or other auto-immune deficiency (A)
___ Pregnant (A)
___ Bleeding abnormalities (A)
___ Treatment with Accutane® in the last six months (A)
___ Kelloid or very thick scarring (A)
___ Psoriasis or Vitiligo (A)
___ Herpes simplex or fever blisters (A)
___ Diabetes (A)
___ Epilepsy (A)
___ Scars that turn white or brown (A)
___ Dark spots after pregnancy, skin injury (A)
___ HIV (A)
___ Hepatitis (A)

___ Pulmonary embolism/blood clot (V)

___ Leg ulcer or Phlebitis (V)

___ Blood thinning medication (V)

___ Rheumatoid Arthritis "Gold" Therapy (A)

___ Cystic Acne (P)

___ Waxing/Plucking/Electrolysis within last four weeks (HR)

___ Hirsutism (HR)

___ Transplant Anti-Rejection Drugs (HR)

___ Chemical Peels, Dermabrasion, Laser Resurfacing or Face Lift (A)

Please list any medications or herbal supplements that you are currently taking:

_____

_____

_____

_____ _____

Patient Signature Date