



## New Patient Form

**Please Print, fill out, and bring to your appointment.**

Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Title: \_\_\_ Mr. \_\_\_ Mrs. \_\_\_ Ms. \_\_\_ Dr.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### **Contact Information**

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

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

How did you hear about us? \_\_\_\_\_

What procedures are you interested in?

\_\_\_ Hair Reduction \_\_\_ YouthPeel TM \_\_\_ Vein Removal

\_\_\_ Acne Treatments Other \_\_\_\_\_

Have you ever had Chemical Peels, Laser Treatments, Electrolysis or Permanent Makeup before? \_\_\_\_ Yes \_\_\_\_ No

If Yes, Please describe the procedures, dates and your results.

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Are you currently under a physicians care?

\_\_\_\_ Yes \_\_\_\_ No

If yes, list reason below:

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Do you have any allergies? Please List.

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What products do you currently use on your skin?(In the areas we will be lasering)

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The skin of some nationalities heals better than others. Please list the nationalities of your grandparents on both your mother's and father's side of the family, so your treatment can be customized to your skin.

My Father's Father was: \_\_\_\_\_

My Father's Mother was: \_\_\_\_\_

My Mother's Father was: \_\_\_\_\_

My Mother's Mother was: \_\_\_\_\_

Have you used Retin-A within the last Year? \_\_\_\_ Yes \_\_\_\_ No

If yes, where did you apply it?

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Are you currently or have you in the past 3 months taken Acutane or Gold Therapy?

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Are you currently taking any mood altering or depression medications?  
\_\_\_\_ Yes \_\_\_\_ No

Do you smoke? \_\_\_\_ Yes \_\_\_\_ No

Please check any of these conditions that apply to you now:

- |                        |                             |                               |
|------------------------|-----------------------------|-------------------------------|
| ____ Diabetes          | ____ Seizures               | ____ Hypo Pigmentation        |
| ____ Tumors or Cysts   | ____ Heart Condition        | ____ Chronic Eye Problems     |
| ____ Tuberculosis      | ____ HIV                    | ____ High Blood Pressure      |
| ____ Bruise Easily     | ____ Skin Disorders         | ____ Liver or Kidney Disorder |
| ____ Skin Allergies    | ____ Cancer                 | ____ Muscular Condition       |
| ____ Herpes            | ____ Pregnant               | ____ Hyper Pigmentation       |
| ____ None of the above | ____ Other (describe below) |                               |

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Please list any medications you are currently taking. (*Including any Herbs or Vitamins*)

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**For Hair Removal ONLY:**

What color is the hair you wish removed?

\_\_\_\_ Brunette \_\_\_\_ Blonde \_\_\_\_ Red \_\_\_\_ Grey or White \_\_\_\_ Black

Please describe the hair's growth:

\_\_\_\_ Heavy, dense & coarse \_\_\_\_ Medium \_\_\_\_ Sparse, light & fine

Please describe your skin tone:

\_\_\_\_ Very fair - Always burn, never tan, blue or green eyes

\_\_\_\_ Light skin - Able to tan, but usually burn, green or brown eyes

\_\_\_\_ Medium skin - Often tan, but sometimes burn, brown eyes

\_\_\_\_ Olive skin - Always tan, never burn, dark eyes

\_\_\_\_ Dark Brown or Black skin - Never burn, black eyes

**For all Procedures:**

I attest to the fact that all the above information is true and that I am not aware of any medical situation that might effect my treatment.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*Note: Before and After photographs will be taken of each area to be treated. These photographs are never displayed without your prior written approval.



## Appointment and Cancellation Policy

In order to ensure that your scheduled appointment time will be held for you, we require one of the following:

- Visa or Master Card # (the number will be checked for authenticity)
- \$50.00 Cash (to be held in your chart)

When we receive one of the above, your scheduled time will be held.

If you choose to use a credit card, we will verify the validity of the credit card number prior to reserving your time on the schedule. If the credit card given to us is not valid, we will make every attempt to contact you so we can remedy the situation. However, we will not reserve your requested time until we are able to acquire a valid credit card number.

If you choose to use cash, we will place it in an envelope in your file as a deposit. When you show up for your appointment, we will return the money to you, or you may leave it on reserve for future appointments. Your requested time will not be held, until the cash is dropped off at our office. Your money will be given back to you at any time you request, provided you do not miss your appointment.

Our Clinic is very busy, but we will be happy to change your scheduled time to a more convenient time for you, as long as you give us at least 24 hours prior notice. In the event you have made an appointment with us, but you forget about it, or you are unable to make it to your appointment for some reason, your \$50.00 deposit will be forfeited. No exceptions.

The recommended time between procedures is a very important aspect of your final outcome, so it is important to stay on track. If you need to change your appointment date, and we do not have an opening for several weeks, this may affect your end results by getting you're timing off track. For the best results please try to stick to the schedule.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

By signing the above you are stating you have read, understand, and will abide by the policy.

Please bring the completed papers to your appointment.