LAFRANCE MEDICAL AESTHETICS
Patient Registration Information

This form is part of your medical record and must be completed in its entirety, please PRINT.

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr. FIRST NAME: _____ LAST NAME: _____

STREET: _____ APT #: _____ ☐ Male ☐ Female

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____-_____-_____ WORK PHONE: _____-_____-_____ CELL PHONE: _____-_____-_____

DATE OF BIRTH: _____/_____/_____ MARITAL STATUS: ☐ Married ☐ Single ☐ Other

EMAIL: _____ May we email you information? ☐ YES ☐ NO

WE RESPECT YOUR EMAIL PRIVACY AND WOULD NEVER RELEASE YOUR EMAIL ADDRESS TO ANY UNAUTHORIZED PARTY.

PREFERRED CONTACT METHOD: ☐ Email ☐ Home Phone ☐ Cell Phone ☐ Work phone

EMERGENCY CONTACT: _____RELATIONSHIP TO YOU: _____ PHONE: _____- _____-_____

WERE YOU REFERRED BY A DOCTOR? ☐ Yes ☐ No If Yes, please give us the contact information of your doctor below:

REFERRING M.D. NAME: _____ SPECIALITY: ☐ DERM ☐ OB/GYN ☐ PCP/FAMILY_____

If No, how did you find out about us? ☐ Website ☐ Family/Friend ☐ Google ☐ Newspaper ☐ Mail ☐ Other_____

If referred by a friend/patient, please tell us who we can thank? _____

FINANCIAL POLICY AND AUTHORIZATIONS

PAYMENT IS EXPECTED FOR ALL OFFICE VISITS, SERVICES, TREATMENTS AND PRODUCTS AT THE TIME OF EACH VISIT. For your convenience, we accept cash, all major credit cards and optional financing plans. The fee for a consultation with the doctor is $50.00. The consultation fee is waived for patients with a referral. The consultation fee will be deducted from any medical procedure or chemical peel fee if booked within 30 days of the consultation. Fees paid for services are non-refundable. ALL products, whether opened or unopened, are non-refundable. Unopened products may be exchanged within 14 days of purchase for product credit only. Opened products and prescription items (Latisse) are not returnable.

CANCELLATION POLICY: 24-hour advance notice is required to reschedule or cancel any appointment. Failure to do so or not show up at an appointment without a phone call will result in a missed appointment / late cancellation fee.

AUTHORIZATON TO OBTAIN AND USE PHOTOGRAPHS: I hereby authorize the physician to obtain photographs before and after my treatments. I understand and agree that these photographs shall be the property of LaFrance Medical Aesthetics as a part of my permanent medical record. I understand and agree that these photographs may be used for internal patient education and/or teaching purposes.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have been presented the Notice of Privacy Practices which details how my health information may be used and disclosed as permitted under federal and state law. The Notice of Privacy Practices has been presented to me at my initial visit; I acknowledge the notice of privacy practices is visible in a conspicuous location at the office and on the practice web site.

Patient or guardian signature _____ Date: ____ /____ / ____

LAFRANCE MEDICAL AESTHETICS
Medical History Assessment

Name: _____ Date: ____/____/_____

Date of Birth: ____/____/_____ Gender: ☐ Male ☐ Female Height: ___'___" Weight_____lbs.

ARE YOU CURRENTLY PREGNANT, NURSING OR PLANNING PREGNANCY? ☐ Yes ☐ No ☐ Does not apply

REASON FOR TODAY'S VISIT

- ☐ Fine lines & wrinkles
- ☐ Lines around the lips / mouth
- ☐ Skin texture
- ☐ Uneven skin tone
- ☐ Brown spots / hyperpigmentation
- ☐ Facial veins/redness
- ☐ Acne scars
- ☐ Acne
- ☐ Unwanted hair
- ☐ Leg veins
- ☐ Sun damage
- ☐ Facial and or Wax
- ☐ Other _____

_____

ETHNIC ORIGIN

Genetic background and reaction to sun exposure determines your response to lasers and other skin treatments.
Please specify **all of your ethnic origin(s)**:

- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Mediterranean
- ☐ Middle Eastern
- ☐ Native American
- ☐ Other _____

SUN EXPOSURE

On first exposure to the full mid-day sun without sun protection does your skin:

- ☐ Always burn, never tans
- ☐ Usually burns, tans less than average
- ☐ Sometimes mild burn, tans average
- ☐ Rarely burns, tans more than average
- ☐ Rarely burns, tans profusely
- ☐ Never burns, deeply pigmented

Level of outdoor activity: (occupation, sports, boating & beach) ☐ High ☐ Medium ☐ Low

Have you had any unprotected sun exposure or used tanning beds in the last 4-6 weeks? ☐ Yes ☐ No
Do you use sunscreen on a regular basis? ☐ Yes ☐ No

ALLERGIES

Are you allergic to Latex? ☐ Yes ☐ No Are you allergic to Lidocaine (a local anesthetic)? ☐ Yes ☐ No
Are you allergic to any medications or have other allergies? ☐ Yes ☐ No If yes, please list:

1. _____ 2._____ 3._____ 4._____

MEDICATIONS

List all medications you are currently taking or applying (including those by prescription, creams, ointments over the counter drugs, vitamins, herbs, blood thinners, aspirin and/or supplements):

1. _____ 2._____ 3._____ 4._____

5. _____ 6._____ 7. _____ 8._____

Have you had any of the following treatments or used any of the products listed below: (Please circle all that apply)

Accutane
Antibiotic for Skin
Alpha/beta-hydroxy acid
Botox / Dysport / Xeomin
Chemical peel
Glycolic acid
IPL
Juvederm / Restylane / Radiesse
Laser:(specify) _____
Microdermabrasion
Steroids
Topical Retinoids

Previous treatment with Gold Therapy?
☐ Yes ☐ No

Have you had any other cosmetic/aesthetic procedures or plastic surgery not listed above? ☐ Yes ☐ No

If yes, please list: _____

LAFRANCE MEDICAL AESTHETICS
Medical History Assessment Continued

PRIOR MEDICAL HISTORY

Primary Care Physician: _____

☐ No prior medical history OR Please circle all that apply regarding your overall health and add other pertinent information:

Acid Reflux / Peptic Ulcer	Cancer Type_____	Heart Disease	Nerve / Muscle Problems
Acne / Cysts	Chest Pain / Tightness	HIV / AIDS	Polycystic Ovary
Anemia	Cold Sores / Fever Blisters	High Blood Pressure	Port Wine Stain
Anxiety	Depression	Hives / Rash	Psoriasis
Arthritis	Diabetes	Keloid / Abnormal Scars	Rosacea
Asthma / COPD	Eczema	Kidney Disease	Seizures / Stroke
Autoimmune Disorder	Excess Bleeding	Liver Disease / Hepatitis	Shingles
Bleeding / Blood Disorders	Eye Problems / Glaucoma	Melasma	Tattoo(s)
Bruises Easily	Fainting Spells	Migraines	Thyroid Disorder
Burns / skin grafts	Herpes	Nail Fungus	Vitiligo

Details or other important medical information: _____

FAMILY HISTORY

☐ No prior medical history OR Please check all that apply regarding your immediate family:

☐ Autoimmune Disorder	☐ Cancer	☐ High Blood Pressure	☐ Skin Cancer
☐ Bleeding / Blood Disorder	☐ Diabetes	☐ Hemophilia	☐ Heart Disease

Please list any other pertinent family history: _____

SOCIAL HISTORY

What is your occupation? _____

Do you smoke? ☐ Yes ☐ No How many packs/day? _____ If you were a smoker, when stopped: _____/_____

Alcohol Consumption: ☐ No ☐ Occasionally ☐ Regularly

History of alcohol or drug abuse? ☐ Yes ☐ No

Do you exercise? ☐ Daily ☐ Few days per week ☐ Occasionally ☐ Never

ARE YOU INTERESTED IN ANY OF THE FOLLOWING?

☐ Relaxers (Botox/Dysport/Xeomin): Eases wrinkles and eliminates hyperhidrosis (excessive sweating)
☐ Facial Fillers (Juvederm/Radiesse/Restylane): Corrects volume loss in cheeks, lips and hands
☐ Laser Skin Resurfacing: improves dyspigmentation, acne scars, fine lines and wrinkles
☐ Mineral Makeup i.e. Colorescience
☐ Chemical Peels/Resurfacing Treatments: Refines, tones and clarifies skin
☐ Body Contouring
☐ Laser Hair Removal
☐ Laser Tattoo Removal
☐ Facial or Leg Vein Removal
☐ Liver spots/age brown spot removal
☐ Light Therapy; Acleara and IPL for active acne and Photofacial
☐ Latisse: FDA approved prescription for longer, thicker, and darker eyelashes
☐ Facials, waxing, medical grade skincare or sun protection products

Patient or guardian signature _____ Date: ____ /____ / ____