Patient Registration Information

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 the contact information of your doctor below:

REFERRING DR NAME:____________________________________ SPECIALTY: ☐DERM ☐OBGYN

If No, how did you find out about us? ☐Website ☐Family/Friend ☐Google ☐Print Ad ☐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 and all major credit cards. The fee for consultation is $75. The consultation fee is waived for patients with referral documentation. 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. 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: All "no-show" appointments will result in a missed appointment/cancellation fee. Cancellation with less than 2 business days notice will result in a no-show fee. For instance, a Tuesday morning appointment requires rescheduling no later than the previous Friday morning. A Thursday morning appoinment requires cancellation rescheduling no later than Tuesday morning. The missed appointment/late cancellation fee is $75. Patient may be discharged from the practice after THREE "no-shows" or cancellations occurring within less than 48 hours' notice. Same day cancellations are acknowledged if emergencies do occur at the discretion of the practice.

AUTHORIZATION TO OBTAIN AND USE PHOTOGRAPHS: I understand that photographs may be taken to document my care, and I consent. I understand that LaFrance Medical Aesthetics will retain the rights to these photographs, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law. Images that identify me will be released and/or used outside the office <u>only</u> upon written authorization from me or my legal representative.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: The notice of Privacy Practices which details how my health information may be used and disclosed as permitted under federal and state law is posted on the practice website; I ackowledge the notice of privacy practices is visible in a conspicuous location at the office and on the practice website.

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

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
☐ Sun damage
☐ Skin texture
☐ Uneven skin tone
☐ Brown Spots
☐ Tired looking/uneven skin
☐ Facial veins/redness
☐ Acne scars
☐ Tattoo Removal
☐ Unwanted hair
☐ Leg veins
☐ Unwanted fat under the chin
☐ Medical Facial/Wax
☐ Longer, thicker eyelashes
☐ Other _________________

ETHNIC ORIGIN

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

☐ African American
☐ Asian
☐ Caucasian
☐ Hispanic
☐ Mediterranean
☐ Middle Eastern
☐ Native American
☐ Other ___________________

SUN EXPOSURE

With your natural, baseline skin tone, if you exposed your skin to the full mid-day sun without sun protection, would your skin:

☐ Always burn, never tan
☐ Usually burn, tan less than average
☐ Mildly burn, tan average
☐ Rarely burn, tan more than average
☐ Rarely burn, tan more than usual
☐ Never burn, deeply pigmented

Do you use sunscreen on a regular basis? ☐ Yes ☐ No
Have you used tanning beds or actively tanned in the last 4-6 weeks? ☐ Yes ☐ No
Level of outdoor activity: (occupation, sports, boating & beach) ☐ High ☐ Medium ☐ Low

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): ☐ None

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 (when) _______
Botox/Dysport/Xeomin
Chemical peel
Gold Therapy
Hair Removal (specify) _______
Injectable Fillers
IPL/Laser (specify) ______
Microdermabrasion
Oral Medication for skin
Skin Tightening
Steroids
Topical Retinoids

Have you had any other cosmetic/aesthetic procedures or plastic surgery not listed above?

If yes, please list: ____

PRIOR MEDICAL HISTORY

Primary Care Physician: ______________________ **Dermatologist:** ______________________
Last Visit: ______________________

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

Acid Reflux/Peptic Ulcer	Burns/Skin Grafts	Heart Disease	Nerve/Muscle Problems
Acne/Cysts	Cancer Type ______	Herpes	Polycystic Ovary
Alcohol/Drug Abuse	Chest Pain/Tightness	HIV/AIDS	Port Wine Stain
Anemia	Cold Sores/Fever Blisters	High Blood Pressure	Psoriasis
Anxiety	Depression	Hives/Rash	Rosacea
Arthritis	Diabetes	Keloid/Abnornmal Scars	Seizures/Stroke
Asthma/COPD	Eczema	Kidney Disease	Shingles
Autoimmune Disorder	Excess Bleeding	Liver Disease/Hepatitis	Tattoo
Bleeding/Blood Disorders	Eye Problems/Glaucoma	Melasma	Thyroid Disorder
Bruises Easily	Fainting Spells	Migraines	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? ______________________ Place of Employment? ______________________

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

Alcohol Consumption: ☐ No ☐ Occasionally ☐ Regularly

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

ARE YOU INTERESTED IN ANY OF THE FOLLOWING? (check off all that apply)

☐ **Botox Cosmetic:** Improves frown lines and wrinkles
☐ **Botox Therapeutic:** Eliminates Hyperhidrosis (excessive sweating)
☐ **Injectable Fillers:** Corrects volume loss in cheeks, folds around the mouth, lips and hands
☐ **Fraxel Dual Laser Skin Resurfacing:** Non-ablative laser that resurfaces damaged skin, improves acne scars, fine lines and wrinkles
☐ **Clear + Brilliant/Permea:** No downtime, addresses skin texture, pigmentation, firmness, elasticity, fine lines and pore size
☐ **Chemical Peels/Resurfacing Treatments:** Refines, tones and clarifies skin
☐ **Dermaplaning:** Manual exfoliation technique that creates a more radiant appearance.
☐ **Kybella:** A minimally invasive treatment that rids submental fat (double chin)
☐ **Latisse:** prescription for longer, thicker and darker eyelashes
☐ **Laser Facial/Leg Vein/Red Spot Removal** ☐ **Laser Tattoo Removal**
☐ **Ultherapy, Laser Genesis: Skin Tightening** ☐ **Laser Brown Spot Removal**
☐ **Medical Facials and Waxing** ☐ **Acne Treatments**
☐ **Medical Grade Skincare and Sun Protection Products** ☐ **Laser Hair Removal**

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