

# 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 \$150. 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 or refundable.

**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 appointment 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:** 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 only 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 acknowledge 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

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Fine lines & wrinkles | <input type="checkbox"/> Uneven skin tone          | <input type="checkbox"/> Acne scars     | <input type="checkbox"/> Unwanted fat under the chin |
| <input type="checkbox"/> Lines around the lips | <input type="checkbox"/> Brown Spots               | <input type="checkbox"/> Tattoo Removal | <input type="checkbox"/> Medical Facial/Wax          |
| <input type="checkbox"/> Sun damage            | <input type="checkbox"/> Tired looking/uneven skin | <input type="checkbox"/> Unwanted hair  | <input type="checkbox"/> Longer, thicker eyelashes   |
| <input type="checkbox"/> Skin texture          | <input type="checkbox"/> Facial veins/redness      | <input type="checkbox"/> Leg veins      | <input type="checkbox"/> 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)**

- |   |                                    |   |  |
|---|------------------------------------|---|--|
| <input type="checkbox"/> African American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Mediterranean  | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Asian            | <input type="checkbox"/> Hispanic  | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> 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:

- |  |   |
|--|---|
| <input type="checkbox"/> Always burn, never tan              | <input type="checkbox"/> Rarely burn, tan more than average |
| <input type="checkbox"/> Usually burn, tan less than average | <input type="checkbox"/> Rarely burn, tan more than usual   |
| <input type="checkbox"/> Mildly burn, tan average            | <input type="checkbox"/> 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) _____ | Hair Removal (specify) _____ | Oral Medication for skin |
| Botox/Dysport/Xeomin  | Injectable Fillers           | Skin Tightening          |
| Chemical peel         | IPL/Laser (specify) _____    | Steroids                 |
| Gold Therapy          | Microdermabrasion            | 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/Abnormal 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:

<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Bleeding / Blood Disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> 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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_