LASER CLINIQÚE℠
Aesthetic Surgical, Medical and Dental Spa

4765 Carmel Mountain Road, Suite 207 · San Diego, CA 92130 · Phone: (858) 481-7701 · Fax: (858) 481-7741 · www.Laser-Clinique.com

Patient Information

Today's Date:_____

Name:_____ SS#_____
Last Name First Name Middle Initial

Home # ( )_____ Cell # ( )_____ Work # ( )_____

Address:_____ Unit/ Apt #: _____

City:_____State:_____ Zip:_____

Occupation: _____ Employer: _____

E-Mail Address: _____ Sex: **F / M** Age:_____ Date of Birth :_____

Marital Status:_____ Name of Spouse: _____ # of children: _____

In case of emergency, who should be notified?_____ Phone ( )_____

Who may we thank for referring you?: My friend_____ recommended the doctor.
My doctor_____ referred me.
Your location is convenient to my HOME/OFFICE (please circle one)
I have heard the Dr. speak on_____
Print Ad/ Publication _____
TV/ Cable_____
Radio_____
Website/Search Engine _____

What is your ethnic background (heritage):_____

Medical History

1. Are you currently under the care of a physician and/or dermatologist? _____Yes _____No
   If yes, please specify: Dr. Name:_____
   Dr. Phone # ( )_____

2. Are you allergic to penicillin, codeine, local anesthetics such as lidocaine, tranquilizers or any other drugs or medicine?
   _____

3. Do you have any food allergies?_____

4. Have you ever had a rash, peeling, swelling or hives?_____

5. What medications or vitamins supplement including over-the-counter medications are you taking?
   _____

6. (Women) Are you pregnant at this time? If so, how many months?_____

7. Are you breastfeeding?_____

8. Have you taken or are on Accutane? _____

9. What topical medications do you use or have you used:
Retin A_____ Renova _____ Hydroquinone _____

10. Have you had aggressive exfoliation to your skin in the last two weeks? _____

11. Are there any health problems of which we should be advised?_____

12. Social History: Do you smoke? (include frequency) _____
Do you use alcohol? (include frequency) _____
Hobby/Leisure Activities: _____

13. Past Medical/Family History: Check if you personally or anyone in your family has:

	Self	Relative		Self	Relative		Self	Relative
Allergies			Asthma			Arthritis		
Eczema			Lung Disease			Diabetes		
Hay Fever			Skin Cancer			Heart Disease		
Hives			Malignant Melanoma			Hypertension		
Psoriasis			Other Cancer			Tuberculosis		

14. Current or Past Problems with:

	Yes	No	If yes, please explain
General Health			
Eyes			
Ears/Nose/Throat/Mouth			
Heart			
Lungs			
Stomach/Bowel			
Kidneys			
Arthritis/Muscles/Joints			
Skin			
Headaches/Seizures			
Psychiatric			
Thyroid/Diabetes			
Blood/Bleeding Disorder			
Allergic/Immunologic			

Major Medical Illnesses/Surgeries: _____

_____

_____

What is the reason for your visit today? _____

On a scale of 1 to 5, circle the appropriate number:

- When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	2	3	4	5

- When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

What skin care products do you currently use? _____Do you use an S.P.F. daily? _____

What other concerns do you have? _____

Please place a check mark by the services that interest you:

_____ Botox®

_____ Juvéderm® & Soft Fillers
_____ IPL Photorejuvenation/ Skin Rejuvenation
_____ Age Spots/Liver Spots/ Sun Damage
_____ ActiveFx/DeepFX/TotalFX (non-surgical facelift/skin tightening)
_____ Mesotherapy/Meso-Slim® (fat & cellulite treatment)
_____ Sclerotherapy (vein treatment)
_____ Fx Lift® (modified facelift with laser resurfacing)
_____ Acne and/or Acne Scars

_____ Skin Care Products
_____ Skin Care Advice

_____ Latisse (for thicker, longer & darker eyelashes)
_____ Other: _____

_____ Excessive Sweating (Hyperhidrosis)

_____ Laser Hair Removal
_____ Vibradermabrasion
_____ Removing Facial Veins
_____ Laser Resurfacing
_____ Removing Leg Veins
_____ Facial Plastic Surgery
_____ Facials & Eye Treatments

_____ Chemical Peels
_____ Mole Removal

_____ Dysport®

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the
Medical Board of California
(800) 633-2322
www.mbc.ca.gov

To the best of my knowledge, I have answered every question completely and accurately. I will inform my doctor/dentist of any change in my health and/or medication.

Patient Signature:_____Date: _____

Patient Name(print)/ Relationship:_____

Doctor Signature:_____ Date: _____

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NO SHOW/LATE CANCELLATION POLICY
NO REFUND POLICY

Laser Cliniqúe's policy and administrative process for addressing no-shows, late cancellations and refunds are listed below:

A **"No-show":** shall be recognized as a person who fails to appear for his/her appointment without notice.

A **"Late Cancellation":** shall be recognized as a person who fails to cancel his/her appointment less than forty-eight (**48**) hours before their scheduled appointment time.

It shall be the policy of Laser Cliniqúe that in the event of either a "No-Show" or a "Late Cancellation," all clients will be assessed a fee of $75.00.

It shall be the policy of Laser Cliniqúe that if a client has three (3) "No-Show" or "Late Cancellation's" on file, Laser Cliniqúe has the right to discharge the patient from the practice forfeiting any and all pre-paid deposits or services.

Laser Cliniqúe has a strict **"No Refund"** policy for cosmetic procedures that have been pre-paid for. Refunds are not allowed due to the time(s) blocked in the schedule for treatments.

To avoid any fees, please call (858) 481-7701 at least 48 hours prior to your appointment time.

We appreciate your cooperation and thank you for your patronage.

Sincerely,

Management

Patient Signature: _____Patient Name (Print): _____
Date:_____/_____/_____

Witness Signature: _____ Witness Name: _____

Date: ____/_____/_____