

PREMIER LASER AND AESTHETICS, L.L.C.
Laser Hair Removal Patient Information Form

Name: _____

Home Phone: _____

Address: _____

Work Phone: _____

City: _____ State _____ Zip _____

Cell Phone: _____

Date Of Birth: _____

Referred By: (Please Circle One)

Phone Book Advertisement Mail Person Internet

What areas are you interested in having treated with the laser?

Do you have any of the following medial conditions (Circle all that apply)

Retin A	Heart Condition	Cold Sores	Dermatitis	Diabetes	Eczema
Accutane	Genital Herpes	Moles	Pace Maker	Hepatitis	Keloid Scars
Acne	Endocrine Problem	Cancer	Blood Disorder	High BP	HIV/AIDS

Current:

Medication: _____

Allergies: _____

What type of hair removal treatments have you had in the past? (Circle all that apply)

Laser Electrolysis Tweezing Waxing Depilatory Creams None

In order to determine if we can safely treat you with the laser, we ask you to complete this question:

What is your Ethnic Background (Please Circle One)

Caucasian	Hispanic	African American	Asian	Italian
Spanish	Middle Eastern	American Indian	Alaskan Native	Other

Do you have any tattoos including permanent make-up? (The alexandrite laser may have adverse effects on the coloring of your tattoos.) If so, location of tattoos:

(Please complete the Fitzpatrick Skin Type Scale on the Skin Type form)

Statement of Practice:

A laser technician may provide prognosis in regard to hair removal; but does not provide a medical diagnosis. The information I have provided is true and complete to the best of my knowledge and I agree to inform Dr. Warnock's office of any medical changes. I understand that permanent hair reduction requires a series of treatments over a period of time. I will adhere to post treatment guidelines provided to me to promote the healing process. I understand there is a 24 hour cancellation policy to reschedule or cancel an appointment

Client Signature: _____

Date: _____