finesse
COSMETIC LASER & LIPO CENTER

Medical History

Last Name:_____ First Name:_____ M.I.:_____ Date:_____

Street:_____

Town:_____ State:_____ Zip:_____

Phone Numbers- Home:_____ Work:_____ Cell:_____
Please circle which number you'd prefer confirmation calls: Home / Work / Cell

D.O.B.:_____ Age_____ How did you hear about us?_____

Email (to receive internet only information and special promotions): _____

Emergency Contact Name and Phone Number: _____

Lifestyle: Please Circle

Smoking	Y N	Amnt (per week): _____	
Alcohol	Y N	Amnt (per month: _____	
Rec Drugs	Y N	Amnt (per month):_____	
Caffeine	Y N	Amnt (per day): _____	
Exercise	Y N	Amnt (per week): _____	

Please indicate if you've had the following:

Laser Treatments □	Depilatories: □	Chemical Peels: □
Tanning Beds: □	Electrolysis: □	Microderm: □
Waxing: □	Cosmetic Surgery: □	Retin-A/Renova: □
Tweezing: □	Botox/Filler: □	Accutane: □ When:_____

Occupation: _____ Please tell us your ethnicity/descent:_____

When was the last time you had a physical exam:_____
Name/Number of Primary Physician:_____

Height:_____ Weight:_____ Have you had any significant weight change in the last year? Y / N
How many pounds have you lost or gained in the last year? (CIRCLE ONE) **+ / -** _____lbs

Please list ALL Allergies that you may have:_____

Have you ever received any blood transfusions? Y N If yes, when? _____

Medical History: **Please Circle if you have or have ever had**

Abnormal Bleeding	Y	N	Asthma/Difficulty Breathing	Y	N	Kidney/Liver Disease	Y	N
Abnormal Clotting	Y	N	Diabetes	Y	N	Auto Immune Disorder	Y	N
Acid Reflux	Y	N	Dizziness/fainting	Y	N	Arrhythmias	Y	N
Anemia	Y	N	Heart Attack	Y	N	Intestinal Problems	Y	N
Angina (chest pain)	Y	N	High Blood Pressure	Y	N	Difficulty Breathing	Y	N
Epilepsy (seizures)	Y	N	Thyroid problems	Y	N	Psychological Illness	Y	N
Sleep Apnea	Y	N	Tuberculosis	Y	N	HIV	Y	N
Cancer	Y	N	Pigment changes after skin injury	Y	N	Hernia	Y	N
Eating Disorder	Y	N	Poor wound healing	Y	N	Hepatitis	Y	N

*Please explain reasons for circling yes to any of the above or please explain other conditions you have not listed above:_____

Have any of your immediate family members ever had any of the above health issues? Y / N
If yes please explain:_____

Do you experience Cold Sores: Y / N Last Outbreak: _____

Do you wear (Please circle): Contacts/Glasses: Y / N Hearing Aid: Y / N Dentures: Y / N

Do you consider yourself to be healthy? Y / N If NO please explain:_____

Have you consulted with any other surgeon: Y / N

Do you understand that the object of any cosmetic procedure is improvement in appearance, not perfection: Y / N

Do you realize that every operation is followed by a period of healing before the tissue returns to normal and the final result is apparent: Y / N

Surgery: Please list any previous surgeries and their dates (including cosmetic surgery):
_____

If you have had cosmetic surgery, were you happy with the results: Y / N If no please explain:_____
_____

Indicate the type(s) of anesthesia received in the past, specify any complications/reactions you may have experienced:

Local	Y____	N____	Reactions:_____
General	Y____	N____	Reactions:_____
Spinal/Epidural	Y____	N____	Reactions:_____

<u>Female patients:</u>

Number of pregnancies:_____ Did you breast feed? Y____ N____ Date of last period:_____

I acknowledge that I have disclosed my complete medical history and the above is complete and accurate to my knowledge of my medical and psychological status.

I am at least 18 years of age or, if not, I am accompanied by a legal guardian. I hereby consent to and authorize that a medical history be taken by the Finesse Laser Center staff. In order to evaluate and plan and help educate me on the possibilities of procedures I can be offered, I understand that photos are helpful and I authorize the taking of photos, which *will be used solely for documentation and be kept confidential.*

Signature: _____ Date:_____
If under 18: Relationship: (circle) Patient Spouse Parent Guardian Signature:_____

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Medications

Client Information:
Name:_____

Allergies:_____

Pharmacy Contact Information:
Pharmacy Name:_____ Pharmacy Phone #:_____
Pharmacy Address:_____ City:_____ State:_____ Zip:_____
*If you do not know the address, please provide at least the Street name and City.

Instructions: **List all medications you are currently taking or have taken within the last sixty (60) days. Fill out thoroughly.**

1. ***If you're not currently taking any medications leave page blank***. Do not cross out.
2. Include all prescription and over-the-counter medications (example: antibiotics, aspirin, antacids), herbal supplements (example: ginseng, ginko), and vitamins (example: multivitamin, Vitamin E). Include medications taken as needed (example: nitroglycerin). Also, include any injections you may have received (example: steroids) in the last two (2) months.
3. Each visit we will have you update this form. At subsequent visits CROSS OFF any medications you no longer take. Indicate the date you stopped taking the medications.
4. NEVER take drugs prescribed for someone else.

Medication List:

Name of Medication, Dose, & Route (Pill? Injections? Other?)	**Directions** (How many times/day do you take this & when)	**Date prescribed**	**Date stopped**	**Medication held due to Procedure?**		**Reasons for taking this Medication**
				Y	**N**	
				Y	**N**	
				Y	**N**	
				Y	**N**	
				Y	**N**	
				Y	**N**	
				Y	**N**	
				Y	**N**	
				Y	**N**	

I acknowledge that I have disclosed my complete medication history and the above is complete and accurate to my knowledge of my medical and psychological status.

Signature:_____

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Practice Policy Statement

A Credit Card Number is required to reserve your appointment.

We require at least 24 hours notice for appointment cancellations or reschedules. If you cancel or reschedule your appointment with less than 24 hours notice or fail to come to your appointment, a $50 charge will be applied to your credit card.

Payment Policy:

We require payment in full at the time that services are rendered or products are purchased. We gladly accept cash, Visa, and MasterCard. WE DO NOT ACCEPT CHECKS. We also offer financing for certain services (minimum dollar amounts apply) through Care Credit. You must be approved by the respective finance company to finance a service. Injectable treatments and products cannot be financed.

Refund Policy:

Finesse Laser Center will not issue refunds for services purchased or rendered. We may, at our sole discretion, issue a full or partial clinic credit for use at our facility. We are committed to setting realistic expectations, however results do vary. Though we do our best to achieve your desired, realistic outcome, we do not issue a refund or credit after treatments are purchased or rendered. Any packages not completed within one year of purchase date forfeit the remaining treatments. Any deposits not used within 6 months of payment are forfeited. Our products may be exchangeable for products, clinic credit, or monetary refund at our sole discretion. ZO products are not exchangeable or refundable.

Please note that quotes and deposits are valid for 30 days

Accepted and agreed to:

_____

Client Signature **Date**

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Patient Acknowledgement of Disclosure Information

My signature below acknowledges the following:

I am aware that I can access Finesse Cosmetic Laser and Lipo Center's

- **Patient Bill of Rights**
- **Privacy Notice**
- **Practice Disclosure**

on their website at www.finesselaser.com. I am aware that the Privacy Notice is also posted in the waiting room. I acknowledge that I can request a hard copy of any of these documents at any time. I have had an opportunity to receive assistance in understanding these documents and have been given the opportunity to ask questions as may be needed.

I also understand this practices position on Do Not Resuscitate (DNR) and Living Wills and that this practice does not honor these directives.

Name of Patient/Representative (please print)_____

Signature of Patient/Representative_____

Date:_____

Above signature was not obtained because:
☐Patient is unable and unaccompanied by a representative.
☐Patient refused to sign