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?____

Do you give us permission to contact you via email/text? (i.e. confirmations, appointment follow ups and promotions?) Y N

Email: ____

Emergency Contact Name and Phone Number: ____

Lifestyle:	Please Circle		Amount	**Please indicate if you've had the following:**		
Smoking	Y	N	Amnt (per week): _____	CoolSculpting: □	Kybella: □	Mesotherapy: □
Alcohol	Y	N	Amnt (per month: _____	Laser Treatments: □	Depilatories: □	Chemical Peels: □
Rec Drugs	Y	N	Amnt (per month):_____	Tanning Beds: □	Electrolysis: □	Microderm: □
Caffeine	Y	N	Amnt (per day): _____	Waxing: □	Cosmetic Surgery: □	Retin-A/Renova: □
Exercise	Y	N	Amnt (per week): _____	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 have:____

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

Medical History: **Please Circle Y or N whether you have or have ever had the following:**

Condition			Condition			Condition		
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 that are 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 Y or N): Contacts/Glasses: Y / N Hearing Aid: Y / N Dentures: Y / N

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:_________________________
____

Have you ever done CoolSculpting, Ultrashape, Liposonix, Kybella, or any other non-surgical fat reduction treatment? __________

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:____

Female patients:

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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COSMETIC LASER & LIPO CENTER

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:____

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 PERSONAL 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 are offered with 6 months no-interest terms only (again minimum dollar amounts apply).

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 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**

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