

# INTAKE FORM

## Patient Information

First Name:	Middle Initial:	Birth Date:	Sex:
Last Name:			
Address:	City:	State:	Zip:
Email: (Required)		Phone:	
<input type="checkbox"/> I want to opt out of upcoming promotions & research trials			

## Please list all that apply

Medication: \_\_\_\_\_

Supplements: \_\_\_\_\_

Allergies: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Dermatologist: \_\_\_\_\_

Plastic/Cosmetic Surgeon : \_\_\_\_\_ OB/GYN: \_\_\_\_\_

## Have you been diagnosed with any of the following (circle all that apply):

acne | arthritis | cancer: \_\_\_\_\_ | diabetes | heart condition | high cholesterol | immunologic disease | other: \_\_\_\_\_

## Emergency contact:

Name:	Relationship:	Phone:
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## Person responsible for payment (if different from above):

Name:	Relationship:	Phone:
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## How did you hear about Cosmetic Laser Dermatology?

- ☐ Internet – Google, Website, Yelp, Facebook, Instagram, Youtube. Please clarify: \_\_\_\_\_
- ☐ Patient Referral. Please provide name: \_\_\_\_\_
- ☐ Doctor Referral. Please provide name: \_\_\_\_\_
- ☐ Other – Event, Newsletter, TV / Media. Please clarify: \_\_\_\_\_

I understand that I am responsible for all charges and that payment is due at time of service. Payment may be made with cash, Visa, MasterCard, American Express, or Discover. We also offer financing plans to help you cover the cost of your procedure, such as Care Credit and Alphaeon. I UNDERSTAND THAT GOLDMAN BUTTERWICK GROFF FABI WU BOEN & LOYAL, COSMETIC LASER DERMATOLOGY DOES NOT BILL INSURANCE. IN ADDITION, I UNDERSTAND I AM NOT ABLE TO SUBMIT ANY CLAIM FOR MEDICARE REIMBURSEMENT. I understand I will be charged a \$250 rescheduling fee if I do not request to cancel my appointment 48 business hours prior to appointment. By signing below, I give permission to have a third party observer in the exam room during my visit.

☐ Please check box if you decline to have a third party observer present in the exam room.

By signing below, I give permission to the policies above.

Print Name of Patient: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent or Legal Guardian if minor

Relationship to Patient:

# ACKNOWLEDGMENT

## NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been made aware of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that I will be notified of any amendments at the next appointment. To protect the privacy of our patients, physicians, and staff, recordings of any kind (ie: audio or video) are strictly prohibited at all times.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Parent/Guardian Name (If Applicable)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## APPOINTMENT REMINDER

We may use and disclose information to contact and remind you about appointments. If you are not home, we may leave this information on your home voicemail, mobile voicemail, text message, or email. Please check the preferred method to receive appointment reminders.

☐ Phone Voicemail    ☐ Text Message    ☐ Email

**Note: By not checking any of the boxes, you agree to receive reminders on all devices listed above.**

## MEDIA OPPORTUNITIES

Our doctors are often asked to be guest experts with local and national media. If the appropriate opportunity arose, would you be interested in sharing your story?

☐ Yes    ☐ No

## OWNERSHIP DISCLOSURE INFORMATION

One or more of the physicians at Goldman Butterwick Groff Fabi Wu Boen & Loyal, Cosmetic Laser Dermatology have vested interests and may serve on boards with companies whose products and/or supplies we use and/or sell. In no way do any of these personal and professional commitments affect their medical decisions with patients. Our doctors are consultants, advisory board members, and/or investigators for the following companies:

### Mitchel P. Goldman, MD

Allergan  
Biofrontera  
Candela Lasers  
Cell Research Corporation  
Cynosure Lasers  
Endo Pharmaceuticals  
Galderma  
Lucy Beauty  
Lumenis Laser Corporation  
Pomega  
RenGenX  
Revance  
SkinCeuticals  
SkinMedica  
Solta  
Thermi  
TR Therapeutics

### Kimberly J. Butterwick, MD

Allergan  
American Academy of Dermatology  
Colorescience  
Galderma  
Histogen  
Merz  
Revance

### William F. Groff, DO

Allergan

### Sabrina G. Fabi, MD

Allergan  
Alastin  
Colorescience  
Endo Pharmaceuticals  
Galderma  
Lumenis  
Merz  
Revance  
Thermi  
Valeant

### Douglas C. Wu, MD, PhD

Allergan  
Athenex  
Cell Research Corp  
Candela  
Dermira  
Galderma  
Merz  
Thermi Aesthetics  
TR Therapeutics

### Monica Boen, MD

Allergan  
Galderma  
Merz  
Biofrontera  
Solta  
Thermi Aesthetics  
Lumenis

### Jameson Loyal, MD

Endo Pharmaceuticals  
Galderma  
Allergan  
Merz  
Sofwave Medical  
CROMA-PHARMA  
Alastin Skincare  
Lumenis  
Accure Acne  
DefenAge  
American Society for Laser Medicine & Surgery  
Biofrontera Bioscience  
Avita Medical

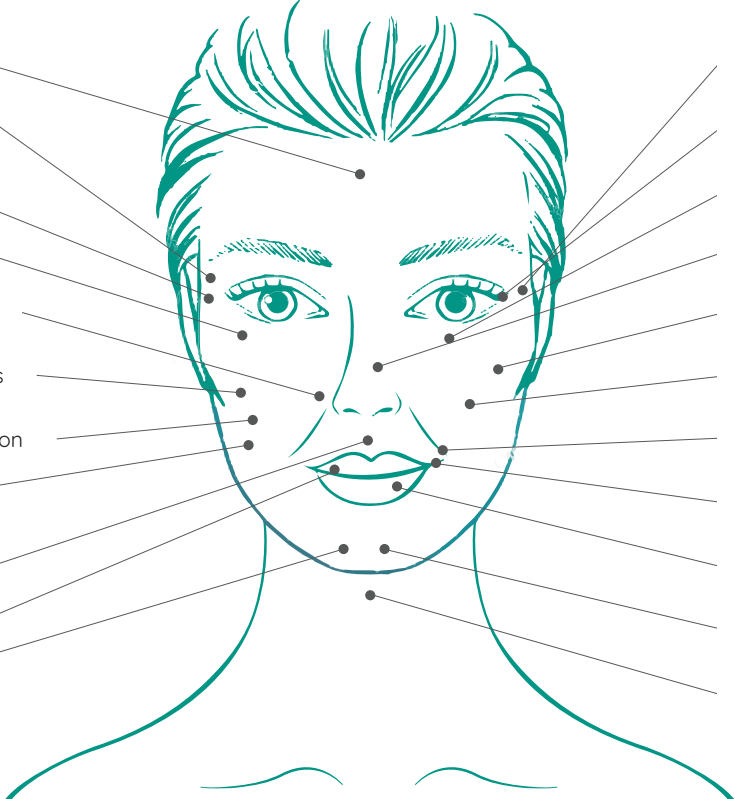
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

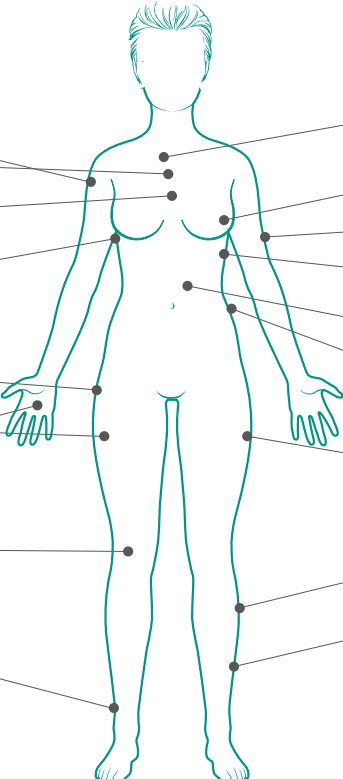
# COSMETIC INTEREST QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please check any concerns you currently experience or would like to discuss:



<input type="checkbox"/> Forehead Lines	<input type="checkbox"/> Temple Hollows
<input type="checkbox"/> Blue Temple Veins	<input type="checkbox"/> Thin & Short Eyelashes
<input type="checkbox"/> Crow's Feet	<input type="checkbox"/> Under Eye Circles
<input type="checkbox"/> Enlarged Pores	<input type="checkbox"/> Nasal Hump
<input type="checkbox"/> Broken Blood Vessels	<input type="checkbox"/> Volume Loss
<input type="checkbox"/> Acne or General Scars	<input type="checkbox"/> Rosacea or Redness
<input type="checkbox"/> Freckles & Pigmentation	<input type="checkbox"/> Nasolabial Folds / Smile Lines
<input type="checkbox"/> Melasma	<input type="checkbox"/> Marionette Lines
<input type="checkbox"/> Vertical Lip Lines	<input type="checkbox"/> Thin Lips / Lip Definition / Lip Fullness
<input type="checkbox"/> Gummy Smile	<input type="checkbox"/> Weak Chin
<input type="checkbox"/> Acne	<input type="checkbox"/> Double Chin /Turkey Neck



<input type="checkbox"/> Flabby Arms	<input type="checkbox"/> Chest Wrinkles
<input type="checkbox"/> Brown/Sun Spots	<input type="checkbox"/> Sagging Breasts
<input type="checkbox"/> Chest Veins	<input type="checkbox"/> Excessive Hair
<input type="checkbox"/> Excessive Sweating	<input type="checkbox"/> Bra Fat
<input type="checkbox"/> Cellulite	<input type="checkbox"/> Loose Skin
<input type="checkbox"/> Saddlebags	<input type="checkbox"/> Love Handles
<input type="checkbox"/> Aging Hands	<input type="checkbox"/> Stretch Marks
<input type="checkbox"/> Sagging Knees	<input type="checkbox"/> Bulging Veins
<input type="checkbox"/> Tattoo Removal	<input type="checkbox"/> Leg Veins

# COSMETIC INTEREST QUESTIONNAIRE

Any other additional services you would like to learn about?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Botox® / Dysport® / Xeomin® /<br>Jeuveau® / Daxxify™ | <input type="checkbox"/> Laser Resurfacing with Fraxel® | <input type="checkbox"/> Liposuction / Liposculpture                   |
| <input type="checkbox"/> Juvederm® / Restylane® / Belotero®                   | <input type="checkbox"/> CoolSculpting®                 | <input type="checkbox"/> ThermiVA® or Viveve® for Vaginal Rejuvenation |
| <input type="checkbox"/> Sculptra® / Radiesse®                                | <input type="checkbox"/> Ultherapy®                     | <input type="checkbox"/> Sclerotherapy / Treatment for Varicose Veins  |
| <input type="checkbox"/> Non-Surgical Brow Lift                               | <input type="checkbox"/> Kybella®                       | <input type="checkbox"/> Microneedling                                 |
| <input type="checkbox"/> Non-Surgical Nose Job                                | <input type="checkbox"/> Thermage™                      | <input type="checkbox"/> Pearly Penile Papules (PPP)                   |
| <input type="checkbox"/> Laser Hair Removal                                   | <input type="checkbox"/> ThermiRF™                      | <input type="checkbox"/> Chemical Peels & Facials                      |
|   | <input type="checkbox"/> Cellfina™                      | <input type="checkbox"/> Custom Skincare Regimen                       |

## MEDICAL DERMATOLOGY QUESTIONNAIRE

What was the date of your last full body skin check?

- ☐ Never Had    ☐ Date \_\_\_\_\_

Have you or anyone in your family ever been diagnosed with skin cancer?

- ☐ Yes    ☐ No    ☐ Not Sure

Do you have any moles that have changed recently in size, color, or shape?

- ☐ Yes    ☐ No    ☐ Not Sure

Do you have any other dermatologic concerns we may be able to help with? (circle all that apply):

- |                       |                |                |
|-----------------------|----------------|----------------|
| Acne                  | Melasma        | Skin Allergies |
| Eczema                | Nail Disorders | Vitiligo       |
| Hair Loss             | Psoriasis      | Warts          |
| Lumps / Bumps / Moles | Rosacea        |                |

What is your current skincare regimen/routine?

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