COSMETIC LASER DERMATOLOGY

INTAKE FORM

Patient Information

First Name: Last Name:	Middle Initial:	Birth Date:	Sex:
Address:	City:	State:	Zip:
Email: (Required) ☐ I want to opt out of upcoming promotions & research trials		Phone: ☐ 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:

Person responsible for payment (if different from above):

Name:	Relationship:	Phone:

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 – Webinar, Event, 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 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:

COSMETIC LASER DERMATOLOGY

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 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
Accure
Allergan
Aurora
Avava
Biofrontera
Cell Research Corporation
Cynosure Lasers
DeepX Health
Galderma
Lucy Beauty
Lumenis Laser Corporation
Pavise
Pomega
Rapalogix
SkinCeuticals
SkinMedica
Solta
TR Therapeutics

Kimberly J. Butterwick, MD
Allergan
American Academy of Dermatology
Colorescience
Galderma
Histogen
Merz
Revance

William F. Groff, DO
No disclosures to report

Sabrina G. Fabi, MD
Allergan
Galderma
L'Oréal
Merz
Revance
XOMD

Douglas C. Wu, MD, PhD
Allergan
Candela
Cynosure Lutronic
Galderma
Lumenis
SkinMedica
Solta

Monica Boen, MD
Allergan
Galderma
Merz
Biofrontera
Solta
Thermi Aesthetics
Lumenis

Jameson Loyal, MD
Acclaro
Accure
Alastin Skincare
Allergan
American Society for Laser Medicine & Surgery
Avita Medical
Biofrontera Bioscience
CROMA-PHARMA
Cynosure
DefenAge
Endo Pharmaceuticals
Galderma
Lumenis
Merz
Sofwave Medical

Raheel Zubair, MD
Allergan
Avita
Babor
Celldex
Pfizer

Kavita Darji, MD
No disclosures to report

Signature

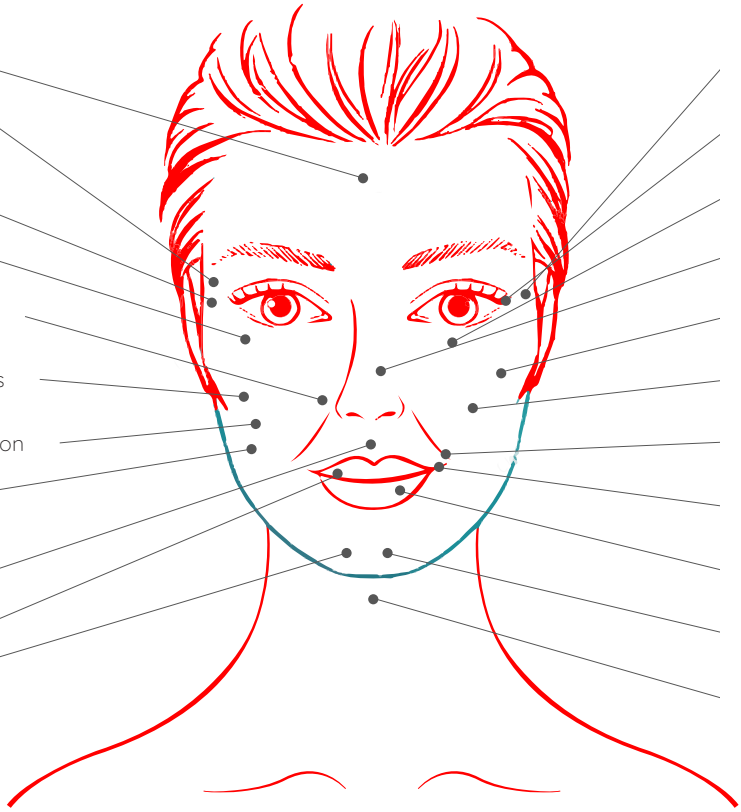
Date

COSMETIC LASER DERMATOLOGY

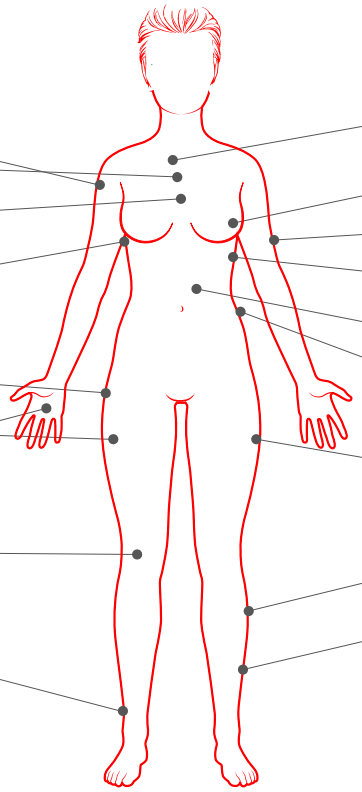
COSMETIC INTEREST QUESTIONNAIRE

Patient Name: _____ Date: _____

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



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



- ☐ Flabby Arms
- ☐ Brown/Sun Spots
- ☐ Chest Veins
- ☐ Excessive Sweating
- ☐ Cellulite
- ☐ Saddlebags
- ☐ Aging Hands
- ☐ Sagging Knees
- ☐ Tattoo Removal
- ☐ Chest Wrinkles
- ☐ Sagging Breasts
- ☐ Excessive Hair
- ☐ Bra Fat
- ☐ Loose Skin
- ☐ Love Handles
- ☐ Stretch Marks
- ☐ Bulging Veins
- ☐ Leg Veins

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COSMETIC INTEREST QUESTIONNAIRE

Any other additional services you would like to learn about?

- ☐ Take10
- ☐ Botox® / Dysport® / Xeomin® / Jeuveau® / Daxxify™
- ☐ Chemical Peels & Facials
- ☐ CoolSculpting®
- ☐ Custom Skincare Regimen
- ☐ Juvéderm® / Restylane® / Belotero®
- ☐ Kybella®
- ☐ Laser Hair Removal
- ☐ Laser Resurfacing with Fraxel®
- ☐ Liposuction / Liposculpture
- ☐ Microneedling / Microneedling with Radiofrequency
- ☐ Non-Surgical Brow Lift
- ☐ Pearly Penile Papules (PPP)
- ☐ Sclerotherapy for Varicose Veins
- ☐ Sculptra® / Radiesse®
- ☐ ThermiSculpt
- ☐ ThermiVA® for Vaginal Rejuvenation
- ☐ TotalTat3 Tattoo Removal
- ☐ Ultherapy™ / Sofwave™ / Thermage® FLX

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

What is your current skincare regimen/routine?