Patient Registration

Name: ____ D.O.B.________________

Address: ____

City: _____________________________ State: _______________ Zip: _______

Home Phone: ______________________ Cell Phone: ____________________

Email Address: ____

May we contact you by phone to confirm appt: Yes: __________ No: _____________

How Did You Heart About Us: ____

Emergency Contact: ____

Phone: ___________________________ Relationship: ____________________

Patient Employer Information:

Employers Name: ___________________ Occupation: ___________________

Telephone #: _______________________

Have you ever had the following?

___ Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or precancerous lesions such as multiple dysplastic nevi.
___ Any active infection.
___ Diseases which may be stimulated by light at 515 nm to 1200 nm, such as history of recurrent Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria.
___ Use of photosensitive medication and/or herbs that may cause sensitivity to 515-1200 nm light exposure, such as Isotretinoin, tetracycline, or St. John's Wort.
___ Immunosuppressive diseases, including HIV infection and AIDS, or use of immunosuppressive medications.
___ Patient history of hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless under control.
___ History of bleeding coagulopathies or use of anticoagulants.
___ History of keloid scarring.
___ Very dry skin.
___ Exposure to sun or artificial tanning during the 3-4 weeks prior to treatment.
___ Have you ever been on Accutane?

If you have answered yes to any of the above, please explain: ___________________
____

Are you pregnant? ______

What medications are you taking (including aspirin) _________________________?
____

Allergies: ____

Daily consumption of alcohol: ____

Do you wear contact lenses? _________

Skin type: (when exposed to the sun without protection for about 1 hour)
___ Always burns, never tans.
___ Always burns, sometimes tans.
___ Sometimes burns, sometimes tans.
___ Always tans.
___ Hispanic, Asian, Mediterranean, Middle Eastern.
___ Black.

Do you use chemical sun tanning lotions? ____________________________________

Are you planning a holiday in the sun? ______________________________________

Which area are you looking to get treated today? ______________________________
____

If treating the facial area, have you ever had fever blisters or cold sores? ___________

Prior Treatment (if any): ____

Informed Consent Soprano Laser Hair Removal

Patient Name: ____

I authorize Sarasota Laser to perform the Soprano Laser Hair Removal procedure and any other measures, which in their opinion may be necessary.

I understand that the Soprano Laser is a device used for laser hair removal and that clinical results may vary in different skin types and hair types. I understand that there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me. (patient initials) _________

I understand that treatment by the Soprano Laser Hair Removal System involves a series of treatments and the fee structure has been fully explained to me. (patient initials) ______

I understand that there will be a $30 late cancellation fee for anyone who cancels less than 24hrs prior to their appointment. (patient initials) _____

Clinical results may vary depending on individual factors including medical history, skin and hair type, patient compliance with pre/post treatment instructions, and individual response to treatment. I understand the epilation with the Soprano System is a safe alternative to methods used for removing unwanted hair; such as shaving, waxing, chemical epilation and electrolysis. (patient initials) ________

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible compilations, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.
(patient initials) ______

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator.
(patient initials) _____

I consent to the taking of photographs and authorize their anonymous use for the purpose of medical audit, education, and promotion. (patient initials) ______

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature: __________________________________ Date: ________________