LANSDOWNE
AESTHETIC CENTER

Patient Information

First Name: _____ Last: _____

Address*: _____

City: _____ State: _____ Zip Code: _____

Home Phone _____ Work Phone: _____

Cell Phone _____ E-Mail _____

Preferred method of contact:_____

Birth Date*: _____ Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Other _____

Spouse's Name _____

Primary Language: _____

Occupation: _____

Company or School: _____

Emergency Contact Information*:

First Name: _____ Last: _____

Home Phone _____ Work Phone:_____

Cell Phone _____ Relation:_____

Reason For Your Visit Today?

How did you hear about us? _____

Patient Medical History

Have you had or have the following?	
☐ Breast Cancer ☐ Cancer ☐ Thyroid Disorder	☐ Tuberculosis ☐ Xray Therapy ☐ No Pertinent Past Medical History

Please check all that apply below:

Eyes:	Endocrine
☐ Double Vision ☐ Eye Pain ☐ Cataracts	☐ Diabetes ☐ Loss of Hair ☐ Heat/Cold Intolerance
Constitutional	**Musculoskeletal**
☐ Fever ☐ Chills ☐ Fatigue ☐ Weight Loss	☐ Joint pain/ Swelling ☐ Stiffness ☐ Muscle Pain ☐ Back Pain

Neurological	Genitourinary
☐ Headaches ☐ Memory Loss ☐ Loss of Strength ☐ Paralysis ☐ Numbness ☐ Epilepsy/ Seizures	☐ Frequent urination ☐ Painful urination ☐ Blood in urine ☐ Abnormal Discharge ☐ Bladder Leakage ☐ Kidney Stone
Respiratory	**Gastrointestinal**
☐ Cough ☐ Wheezing ☐ Congestion ☐ Shortness of Breath ☐ Asthma ☐ Emphysema ☐ Bronchitis	☐ Heartburn/ Reflux ☐ Nausea/ Vomiting ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Cramping ☐ Ulcers

Ears, Nose, Throat	Hematology/ Lymph
☐ Sore throat ☐ Sinus Trouble ☐ Stuffy Nose ☐ Hearing Loss	☐ Anemia ☐ Bruising Easily ☐ Bleeding Easily ☐ Enlarged Glands

Skin	Psychiatric
☐ Rash ☐ Sores ☐ Lesions ☐ Itching/Burning ☐ Skin Cancer	☐ Anxiety ☐ Depression ☐ Mood swings ☐ Difficulty Sleeping

Patient Medical History Continued:

Please check all that apply below:

Allergic/Immunologic
☐ Hives ☐ Hay Fever

Cardiovascular
☐ Chest Pain ☐ Dizziness ☐ Shortness of Breath ☐ High Blood Pressure ☐ Palpitations ☐ Heart Attack ☐ Heart Murmur ☐ Irregular Heartbeat ☐ Blood Clots ☐ Pacemaker ☐ Stroke

Do you have the following Allergies:	Other Allergies:
☐ Latex ☐ Food ☐ Adhesives	

Do you have history of the following:
☐ HIV/AIDS
☐ Hepatitis C or B
☐ STD(s)

Patient Ability to Heal

	Yes	No
Does your skin appear fragile, burns easily? Do you form thick or raised scarring from a cut or burn? Do you wax or use depilatories on your face? Do you ever get cold sores?		

Height (ft. in.)_____ Weight (lbs) _____

Please list any past surgeries:	Date:

Patient Medical History Continued:

Please list current medications including vitamins and supplements:		
Drug	**Dosage**	**Prescribed By:**

Patient Social History

Alcohol	Illegal Drugs	Tobacco
☐ Denies Alcohol Use ☐ Admits Alcohol use socially ☐ Admits Alcohol use daily	☐ Denies using illegal drugs ☐ Admits to using illegal drugs ☐ Admits to history of Drug Abuse	☐ Non-Tobacco user ☐ Current Tobacco user ☐ Smokeless Tobacco user (chew, snuff, etc)

Female Questions

	Yes	No
Do you have regular periods? Are you going through menopause? Are you pregnant or lactating? During pregnancy, did you ever get hyperpigmentation or masking?		

Patient Family History

Please check all that apply below to family members:

☐ Abnormal Bleeding	☐ Hemophilia
☐ Abnormal Clotting	☐ High Blood Pressure
☐ Adopted	☐ Kidney Disease
☐ Anesthesia Problems	☐ Liver Disease
☐ Autoimmune Disorders	☐ Lung Cancer
☐ Brain Tumor	☐ Malignant Hyperthermia
☐ Breast Cancer	☐ Ovarian Cancer
☐ Cleft Lip	☐ Prostate Cancer
☐ Cleft Palate	☐ Skin Cancer
☐ Diabetes	☐ Skin Disease
☐ Drug Allergies	☐ Other Cancer
☐ Endocrine Disease	☐ Substance Abuse
☐ Hearing Loss	☐ No Contributing Family History
☐ Heart Disease	

MEDICAL HISTORY VERIFICATION: All information provided above is accurate and complete to the best of my knowledge:

Patient Signature: _____ Date: _____

HIPPA and Cancelation Policy

Initials

All Appointments* Require a 48 Business Hour Notice (Monday appointment must be canceled Thursday of the previous week)

Cosmetic Missed Appointment Fees (i.e. Botox, Restylane, Cosmetic Consults including Breast Augmentation, Liposuction etc.): I will be assessed a $150 Fee if I miss a cosmetic appointment without having given this prior notice of cancellation.

Laser Appointments will be charged for the full Laser Treatment if the 48 business hour notice is not given

***Surgery Appointments (i.e. Liposuction, Eyelid Surgery, Breast Augmentation, Abdominoplasty, procedures requiring deposits): I understand I will lose my deposit if my appointment is not cancelled at least 7 business days prior to treatment.**

All No-Show Appointments will require a credit card on file if you would like to reschedule your appointment.

Insurance Information

Initials

We will bill your insurance company if we participate with that company. I am responsible for any and all charges that my insurance company does not cover such as deductibles, co-pays and non-covered services, which are payable at the time of service. Parents are responsible for payments on child accounts. For your convenience we accept most major credit cards. We do not accept checks.

HIPPA-Biopsy/Lab results phone number HIPPA-Disclosure of Lab &/or Biopsy Results

Name of Contact Relation to Patient

To whom if anyone, may we disclose laboratory/biopsy results or other care/financial issues

HIPPA Acknowledgement- Notice of Privacy Practices

Initials

Please initial that you are acknowledging that you have had an opportunity to review, if desired, this practice's "Notice of Privacy Practices."