Bella Plum Laser Studio 4425 N. Central Expressway, Suite 42 Dallas Texas 75206
214.647.1306 beplumbeautiful@gmail.com www.beplumbeautiful.com

PATIENT DEMOGRAPHIC WORKSHEET

PATIENT NAME	DATE OF BIRTH	AGE	SEX	MARITAL STATUS	RACE

MAILING ADDRESS	APT/STE/PO BOX#

CITY	STATE	ZIP CODE	

PATIENT PRIMARY PHONE NUMBER	EMERGENCY CONACT	EMERGENY CONTACT PHONE

PATIENT SECONDARY PHONE NUMBER	PATIENT OCCUPATION OR FT/PT STUDENT	PATIENT WORK PHONE NUMBER

PATIENT PRIMARY E-MAIL	REFERRED TO THIS PRACTICE BY

RESPONSIBLE PARTY WORKSHEET, IF PATIENT IS A MINOR

RESPONSIBLE PARTY'S NAME	RELATIONSHIP TO PATIENT	RESP PRIMARY PHONE

MAILING ADDRESS	APT/STE #	RESP WORK PHONE

CITY	STATE	ZIP CODE	SSN

Please check the boxes of the cosmetic/skin treatments have you had in the past?

	Chemical Peels/Microdermabrasion	WHEN	RESULTS
	Botox/Collagen/Restylane/Silicone/Thermage	WHEN	RESULTS
	Hair Removal by Laser/Electrolysis/Waxing/Tweezing	WHEN	RESULTS
	Laser Face Resurfasing/Photofacials	WHEN	RESULTS
	Vein treatments by Scerotherapy/Laser	WHEN	RESULTS
	Facelift/Eyelid surgery/Liposuction	WHEN	RESULTS
	Tanning booths/Chemical tanning lotions	WHEN	RESULTS

What are your current skin care/make-up products? _____
_____
_____

What are the changes that you would like to see in your skin? _____
_____
_____
_____
_____
_____

REVIEWED BY	DATE

Patient Name:_____ Date_____

NEW PATIENT MEDICAL BACKGROUND

Patient Profile	YES	NO
Allergies (food or drug) ---------- Specify: _____	☐	☐
Pregnant or attempting pregnancy? ---------	☐	☐
Do you have signs of menopause? ----------	☐	☐
Have you had a hysterectomy? ----------	☐	☐
Are you taking hormone replacements? ----	☐	☐
Are you or have you had radiation? ---------- Where/When? _____	☐	☐
Have you had any recent surgeries? -------- Specify: _____	☐	☐
Smoker? ----------	☐	☐
Have you ever had a Chemical Peel? -------	☐	☐
Have you ever had any injectables?---------- Specify (area & date)_____	☐	☐
What type of work do you do?_____		

	YES	NO
Are you being seen by a physician? --------- Specify: _____	☐	☐
Experienced fertility problems? ----------	☐	☐
Have you completed menopause? ----------	☐	☐
Were you ovaries removed? ----------	☐	☐
Are you a cancer patient? ----------	☐	☐
Ever diagnosed with skin cancer? ---------- Where/When ? _____	☐	☐
Implants, tattoos, permanent make-up? ---- Specify: _____	☐	☐
Do you sunbathe or use tanning beds? ----- How often?_____	☐	☐
Do you use sunscreen/sunblock? ----------	☐	☐
Do you wax? ----------	☐	☐
Do you wear contacts? ----------	☐	☐
Do you participate in aerobics or sports? ---	☐	☐

Do you have a history of any of the following conditions?

Diabetes ----------	☐	☐	High Blood Pressure ----------	☐	☐
Blood Transfusion ----------	☐	☐	Malignancies ----------	☐	☐
Blood Disease ----------	☐	☐	Hepatitus A, B or C ----------	☐	☐
Seizures ----------	☐	☐	Herpes Simplex I, II or III ----------	☐	☐
HIV ----------	☐	☐	AIDS ----------	☐	☐
STDs ----------	☐	☐	Keloids ----------	☐	☐
Metal Plates ----------	☐	☐	Thyroid ----------	☐	☐
Neurological ----------	☐	☐	Polycystic Ovarian Syndrome ----------	☐	☐

Have/are you currently taking any of the following medications?

Testosterone ----------	☐	☐	Anabolic Steroids ----------	☐	☐
Aidactone ----------	☐	☐	Thyriod ----------	☐	☐
Minoxidil ----------	☐	☐	Retin-A/Retinol ----------	☐	☐
Chemotherapy ----------	☐	☐	Blood Thinners ----------	☐	☐
DHEA ----------	☐	☐	Tetracycline ----------	☐	☐
NSAIDs ----------	☐	☐	Antidepressants ----------	☐	☐
Doxycycline ----------	☐	☐	Antibiotics ----------	☐	☐
Accutane ----------	☐	☐	Birth Control ----------	☐	☐

Please list any other medical conditions you have:

_____

_____

_____

Please list any other medications/herbal supplements/vitamins you are presently taking:

_____

_____

_____

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Effective October 2013

Patient Name:_____ Date_____

FITZPATRICK SKIN TYPING

Please circle the choices that best describe you and your skin

SCORE	0	1	2	3	4	
What is your eye color	Light Blue	Blue, Gray or Green	Blue/Hazel	Brown	Brownish Black	
What is the natural color of your hair	Sandy, Red	Blonde	Dark Blonde/Light Brown	Chestnut/Brown	Black	
What is the color of your non-exposed skin	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown	
Do you have freckles on unexposed areas	Many	Several	Few	Incidental	None	
What happens when you stay in the sun too long	Painful, redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely Burns	Never Burns	
To what degree do you turn brown	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly	
Do you turn brown after several hours of sun exposure	Never	Seldom	Sometimes	Often	Always	
How does your face react to the sun	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem	

TOTAL (SKIN TYPE)

SKIN TYPE I	Never tans, always burns (extremely fair skin, blonde/red hair)
SKIN TYPE II	Occasionally tans, usually burns (fair skin, sandy to brown hair, green/brown eyes)
SKIN TYPE III	Often tans, sometimes burns during first exposure to sun (medium skin, brown hair)
SKIN TYPE IV	Always tans, never burns (olive skin, brown/black hair)
SKIN TYPE V	Never burns (dark brown skin, black hair)
SKIN TYPE VI	Never burns (black skin, black hair)

Skin Type Score	Fitzpatrick Skin Type
0 - 7	**I**
8 - 16	**II**
17 - 25	**III**
25 - 30	**IV**
Over 30	**V - VI**

NOTES

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BELLA PLUM LASER STUDIO OFFICE POLICIES

Patient Name: _____

HOURS:
Tuesday - Friday 10:30am - 5pm, Saturday 11am - 5pm, CLOSED Sunday and Monday

PAYMENT:
Payment in full is due at the time of services.

CONTACT / INSURANCE INFORMATION:
Patients are responsible to contact our office and provide us with any and all new contact information when it changes. This includes any changes to: name, address, phone numbers, email addresses, employer, insurance, and responsible parties. Failure to do so may result in our inability to contact you regarding your healthcare and financial concerns which may lead to your dismissal from Bella Plum Laser Studio.

SOCIAL SECURITY NUMBERS & DRIVERS LICENSE:
Bella Plum Laser Studio requires the patient and policyholder's social security to remain on file on all accounts. It is also office policy to obtain drivers licenses of patients 18 years of age and older or the responsible party if the party is under 18 years of age.

APPOINTMENTS:
All patients are seen by appointment only. Our office will make a courtesy call to confirm all appointments 3-4 days prior to your appointment. Due to the nature of our practice, we occasionally need to reschedule an appointment you have made and appreciate your understanding should this occur. We ask that you ***give us at least 24 hours notice if you need to reschedule*.**

CANCELLATIONS/"NO-SHOW":
- **A PATIENT WHO MISSES, CANCELS OR RESCHEDULES LESS THAN 24 HOURS OF THEIR SCHEDULED APPOINTMENT WILL BE CONSIDERED A "NO-SHOW".**
- **THESE PATIENTS WILL BE CHARGED A $25-$75 NO-SHOW FEE BASED UPON THE TYPE OF APPOINTMENT THEY MISS.**

CANCELLATIONS OR RESCHEDULES MAY BE MADE BY
PHONE M – F, 9AM-7PM, SAT 10AM-7PM OR BY E-MAIL UNTIL MIDNIGHT

TELEPHONE:
During office hours the Bella Plum staff attempts to answer each call. However, when phone lines are busy, please leave a voicemail. If you have a medical question or concern, our staff will take your information, and our clinical staff will return your call.
After office hours, a Physician is on call at all times for emergency situations only. *Patients may be charged for non-emergent calls made to the on-call Physician.*
If you feel you have an emergency that cannot wait for regular office hours, please go to the nearest emergency room and they will contact the on-call Physician. For urgent issues that must be addressed outside our normal office hours, please email us at **beplumbeautiful@gmail.com**.

PRESCRIPTION REFILLS:
Please contact your pharmacy for all prescription refills. The Pharmacy will contact our office with any concerns.

Please sign here to confirm that you agree to all of the terms of the Bella Plum Laser Studio Office Policy document.

_____
NAME OF RESPONSIBLE PARTY DATE