



PATIENT DEMOGRAPHIC WORKSHEET

PATIENT INFO	PATIENT NAME	MARITAL STATUS	DATE OF BIRTH	SEX	AGE	RACE	
	STREET ADDRESS					APT/SUITE#/PO Box #	
	City		STATE	ZIP	SSN		
	PATIENT HOME PHONE		EMERGENCY CONTACT			EMERGENCY CONTACT PHONE	
	PATIENT EMPLOYER/SCHOOL NAME		PATIENT OCCUPATION (IF STUDENT, INDICATE FULL TIME OR PART TIME)			PATIENT WORK PHONE	
	PATIENT EMAIL ADDRESS		REFERRED TO THIS PRACTICE BY:			PATIENT MOBILE PHONE	

AREAS OF CONCERN

FACE

- Spots (hyper/hypopigmentation) -----
- Acne -----
- Broken blood vessels -----
- Pores -----
- Wrinkles -----
- Sagging -----
- Neck Problems -----

BODY

- Spots (hyper/hypopigmentation) -----
- Acne -----
- Broken blood vessels -----
- Spots -----
- Cellulite -----
- Sagging skin -----

HAIR REDUCTION

- Face -----
- Under Arms -----
- Arms -----
- Chest -----
- Abdomen -----
- Bikini/Brazilian -----
- Legs -----
- Other: _____

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

	WHEN	RESULTS
Chemical Peels/Microdermabrasion	WHEN	RESULTS
Botox/Collagen/Restylane/Silicone/Thermage	WHEN	RESULTS
Hair Removal by Laser/Electrolysis/Waxing/Tweezing	WHEN	RESULTS
Laser Face Resurfacing/Photofacials	WHEN	RESULTS
Vein treatments by Sclerotherapy/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? _____



FITZPATRICK SKIN TYPING

- 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)

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



NEW PATIENT MEDICAL AND SKIN HISTORY

Patient Name: _____

Patient Profile

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

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

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

Diabetes -----	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure -----	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion -----	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies -----	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease -----	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B or C -----	<input type="checkbox"/>	<input type="checkbox"/>
Seizures -----	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Simplex I, II or III -----	<input type="checkbox"/>	<input type="checkbox"/>
HIV -----	<input type="checkbox"/>	<input type="checkbox"/>	AIDS -----	<input type="checkbox"/>	<input type="checkbox"/>
STDs -----	<input type="checkbox"/>	<input type="checkbox"/>	Keloids -----	<input type="checkbox"/>	<input type="checkbox"/>
Metal Plates -----	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid -----	<input type="checkbox"/>	<input type="checkbox"/>
Neurological -----	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Ovarian Syndrome -----	<input type="checkbox"/>	<input type="checkbox"/>

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

Testosterone -----	<input type="checkbox"/>	<input type="checkbox"/>	Anabolic Steroids -----	<input type="checkbox"/>	<input type="checkbox"/>
Aidactone -----	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid -----	<input type="checkbox"/>	<input type="checkbox"/>
Minoxidil -----	<input type="checkbox"/>	<input type="checkbox"/>	Retin-A/Retinol -----	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy -----	<input type="checkbox"/>	<input type="checkbox"/>	Blood Thinners -----	<input type="checkbox"/>	<input type="checkbox"/>
DHEA -----	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline -----	<input type="checkbox"/>	<input type="checkbox"/>
NSAIDs -----	<input type="checkbox"/>	<input type="checkbox"/>	Antidepressants -----	<input type="checkbox"/>	<input type="checkbox"/>
Doxycycline -----	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics -----	<input type="checkbox"/>	<input type="checkbox"/>
Accutane -----	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control -----	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other medical conditions you have:

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



BELLA PLUM LASER STUDIO OFFICE POLICIES

Patient Name: _____

HOURS:

Monday - Friday 9am-7pm and Saturday 10am-7pm

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, from noon – 1pm and 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 and have received a copy for your records.

NAME OF RESPONSIBLE PARTY

DATE