D A V I D   G R E E N ,   M . D .   B E T H E S D A
4800 Montgomery Lane, Suite M50 ● Bethesda, Maryland, 20814
(301) 907-7250 ● Fax: (301) 907-7234 ● www.LaserDerm.net

C O S M E T I C   &   L A S E R   C E N T E R   O F   A N N A P O L I S
24 Defense Street ● Annapolis, MD 21401
(410)974-6444 ● Fax: (410) 974-6873 ● www.AnnapolisCosmeticCenter.com

LASER HAIR REMOVAL REGISTRATION

Date: ___/___/_____ **How were you referred?** Internet □ Physician□ Patient□ Other: ____________________

Name of referring physician: Dr. ____________________ **Name of primary care physician: Dr.** ____________________

GENERAL INFORMATION

First Name: ____________________ M.I.: ______ Last Name: ____________________

Address: ____________________ City: ____________________ State: ______ Zip: ____________

Age:____ Date of Birth: ____/____/____ LAST 4 of SS#: ________ Marital Status: ____________ Spouse's Name: ____________

Occupation: ____________________ Employer: ____________________

Employer Address: ____________________

Telephone **Home:** (_____) ______-________ **Business:** (_____) ______-________ **Cell:** (_____) ______-________

Contact number during work hours: Home□ Business□ Cell□ Contact number after work hours: Home□ Business□ Cell□

Emergency Contact: Name: ____________________ Phone: (_____) ______-________ Relationship ____________

E-MAIL: ____________________ YES / NO Please register me for email updates *(we do NOT share email addresses with other businesses)*

MEDICAL INFORMATION

What area/s are you interested in treating? ____________________

What method of hair removal are you currently using on the site/s to be treated? ____________________

Have you ever had a "fever blister", "cold sore" or Herpes Simplex outbreak on the site/s that you would like to have treated? YES / NO

If YES, please provide details (frequency of occurrence, date of last outbreak, etc.) ____________________

Do you currently have a tan where your unwanted hair is located? YES / NO

Have you ever had laser hair removal? YES / NO *If YES, please provide details:* ____________________

Are you prone to scarring? YES / NO *If YES, please provide details:* ____________________

Are you prone to brown patches after minor injuries? YES / NO *If YES, please provide details:* ____________________

Have you ever been tested for hepatitis? YES / NO *If YES, please provide details:* ____________________

Have you ever been tested for HIV? YES / NO *If YES, please provide details:* ____________________

List all current medications: ____________________

ALLERGIES to medications: ____________________

List all current medical problems: ____________________

THIS SECTION TO BE COMPLETED BY WOMEN

Are you pregnant? YES / NO Is there a possibility that you are pregnant? YES / NO

Have you ever had any menstrual irregularity? YES / NO *If YES, please provide details:* ____________________

COSMETIC INTEREST ***(optional) - Please check additional interests***

☐ BOTOX® Cosmetic	☐ VANQUISH Fat Removal	☐ THERMAGE CPT	☐ VEIN TREATMENTS
☐ BOTOX® for Under Arm Sweat	☐ IPL PHOTO-FACIALS	☐ TATTOO REMOVAL	☐ ENDOVENOUS ABLATION
☐ JUVEDERM XC	☐ SKIN CARE & PRODUCTS	☐ SKIN CANCER SCREENING	☐ MICRO-NEEDLING
☐ VOLUMA XC	☐ FACIALS	☐ PEELS	☐ MICRODERMABRASION

A L L P A T I E N T S - P L E A S E I N I T I A L & S I G N

Please add any additional comments: ____

I certify that the above information is true to the best of my knowledge. _______

I certify that a HIPAA Form has been completed. _______

_______I understand that I will be responsible for any charges that are incurred on my behalf including insufficient funds, bank charges, attorney fees and/or collection fees.

_____ Cancellation Policy: We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

SIGNATURE: ____ DATE: ____________________