ALBUQUERQUE
LASER CENTER

Patient Registration

Date______________________

Name__________________________________ Birthdate __________________ Age ______ Sex M / F

Social Security # ________________________ Marital Status S M W D Sep

Address____
Street Apt. # City State Zip

Patient's Employer ____ Occupation ______________________

Employer Address ____Telephone #______________________

Primary Doctor _______________________________**Primary Dr. Telephone #** _________________________

Preferred Pharmacy_____________________________ **Pharmacy Telephone #**__________________________

How to contact you:

We take your privacy very seriously.
If we need to contact you regarding your care, please identify the best way to reach you.

Home Phone__________________________
- ❑ OK to leave detailed message.
- ❑ Leave general message with call back number only.

Cell Phone ___________________________
- ❑ OK to leave detailed message.
- ❑ Leave general message with call back number only.

Work Phone__________________________
- ❑ OK to leave detailed message.
- ❑ Leave general message with call back number only.

Fax
- ❑ OK to fax to this number __________________________________

E-mail
- ❑ OK to e-mail to this web address ____________________________

If we are unable to speak directly with you, please list spouse, family members or friends with whom we can speak regarding your appointments, surgical dates, or other personal health information.

Name___________________________ Telephone #_________________ Relationship____________

Name___________________________ Telephone #_________________ Relationship____________

Whom should we contact in the event of an emergency?

Name___________________________ Telephone #_________________ Relationship____________

Current Medical Conditions
Have you ever been treated for any of the following conditions? (Circle all that apply)

Blood Diseases
Cancer (Specify:___________)
Diabetes
Glaucoma
Hepatitis
High Blood Pressure
Keloid Scars
Oral Herpes Simplex (cold sores)
Pre-cancerous skin lesions
Seizure Disorder
Sexually Transmitted Disease

Please list any other conditions for which you are or have been under a physician's care:
____
____

Current Medications:
Are you taking any of the following medications? (Circle all that apply.)

Accutane
Aldactone
Anabolic Steroids
Antidepressants
Birth Control
Blood Thinners
Chemotherapy
DHEA
Hormones
Minoxidil
NSAIDS
Retin-A
Testosterone
Tetracycline
Thyroid Medications

Please list any other medications you are presently taking:
____
____

Please list any known allergies to medication, foods, etc:
____
____

FEMALES ONLY: Are you pregnant, possibly pregnant or considering pregnancy
in the near future? ______Yes ______No

Skin Protocol:
Please circle the category that best describes your skin color and tendency to sunburn:

I. Very white or freckled always sunburn.
II. White usually sunburn
III. White to Olive sometimes sunburn
IV. Brown rarely sunburn
V. Dark Brown very rarely sunburn
VI. Black never sunburn

Please circle the category that best describes your skin type:

I. Problematic (Acne, Psoriasis, Rosacea, Eczema)
II. Oily
III. T-zone or Combination Skin
IV. Normal
V. Dry
VI. Sensitive (Allergic reactions to some skin care products)

Patient Name____ DOB_____________

Previous Cosmetic Facial Treatments:

Botox®	Y	N	Date: __________
Chemical Peel	Y	N	Date: __________
Dermal Fillers	Y	N	Date: __________
Facial Surgery	Y	N	Date: __________
Intense Pulsed Light Tx	Y	N	Date: __________
Laser Treatments	Y	N	Date: __________
Microdermabrasion	Y	N	Date: __________
Tanning (last 4 weeks)	Y	N	Date: __________ ☐Sun ☐Tanning Bed
Tattoo/Permanent Make-up	Y	N	Date: __________

Areas of Concern Regarding Your Skin:

- ☐ Age Spots/Brown Spots
- ☐ Acne Scars
- ☐ Aging Hands
- ☐ Better Overall Skin Care
- ☐ Desire Fuller Eyelashes
- ☐ Eye Wrinkles/ Dark Circles
- ☐ Facial Redness/ Veins
- ☐ Facial Wrinkles
- ☐ Forehead / Frown Lines
- ☐ Lip Lines
- ☐ Leg Veins
- ☐ Skin Discoloration
- ☐ Tattoo Removal
- ☐ Unwanted Facial Hair
- ☐ Unwanted Body Hair
- ☐ Volume Loss/ Sagging Skin
- ☐ Other:____________________
  ____

What skin care products do you use regularly:

Product Name

Facial Cleanser ____

Facial Toner ____

Facial Moisturizer ____

Sunscreen / Sunblock ____

Make-up ____

How did you hear about us? ____Mail ____ Newspaper Ad _____Website _____ Radio Ad

Physician/Dentist____

Salon ____

Friend____

Would you like to receive our special e-mail offers? _____Yes _____ No

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I have answered these questions truthfully and will notify ALC of any changes in medications or my physical conditions. I have received or viewed on-line a copy of the ALC Privacy Policy. If I have given permission to leave detailed messages, fax or e-mail information regarding my care, and/or discuss my medical care with specific family and/or friends, I understand that I am granting a waiver of my privacy rights under HIPAA. If I decide to change these instructions, I will notify ALC in writing as soon as possible. If I have given my email address above, I understand that email is not privacy protected.

Patient Signature____ Date ___________________

Patient Name____ DOB_________________

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Registration for a Minor**

****A minor is a young person under the age of 18 years.**

Patient Name____ Birthdate ________________

It is legally necessary for this office to have written consent from an adult for the medical treatment of a minor. Consent for treatment can **only** be given by a natural or adoptive parent, an adult with legal custody of the minor, or a legally appointed guardian. For this reason, please identify your relationship to the minor patient and the legal basis for your authorization of treatment.. Please check the status that applies:

I am the ________ biological / adoptive parent __________ legal custodian

________ court-appointed guardian of the minor seeking medical treatment.

Minor child resides with

_____ biological / adoptive parents

_____ biological / adoptive mother

_____ biological / adoptive father

_____ Legal Custodian

_____ Court-appointed Guardian

The information indicated on this form is true and accurate to the best of my knowledge.

_____________________________________ _________________________ ______________
Signature Relation to child Date

NOTE to Legal Custodians and Legal Guardians: You may be asked to provide proof of your status. Please bring a copy of your legal documents to the office at the time of the child's visit.