

# lavé md

LASER AND VEIN ESTHETICS

## PATIENT INFORMATION UPDATE

Today's Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home: (\_\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_\_) - \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_

Social Security: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ E-mail: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Has there been a change in your insurance?  YES  NO

Please put a check mark next to the procedures about which you would like to receive more information:

- |   |   |
|---|---|
| <input type="checkbox"/> BOTOX <sup>®</sup> Cosmetic            | <input type="checkbox"/> Skin Care Advice               |
| <input type="checkbox"/> Restylane /Juvaderm                    | <input type="checkbox"/> Skin Care Products             |
| <input type="checkbox"/> Collagen Stimulation                   | <input type="checkbox"/> Skin exfoliation               |
| <input type="checkbox"/> Collagen Replacement                   | <input type="checkbox"/> Make up                        |
| <input type="checkbox"/> Fine Lines                             | <input type="checkbox"/> Sunscreen Advice               |
| <input type="checkbox"/> Deep Lines and Wrinkles                | <input type="checkbox"/> Facials                        |
| <input type="checkbox"/> Age Spots                              | <input type="checkbox"/> Eye Treatments                 |
| <input type="checkbox"/> Brown Spots / Sun Damage               | <input type="checkbox"/> Dry Skin                       |
| <input type="checkbox"/> Liver Spots / Sun Spots                | <input type="checkbox"/> Oily Skin                      |
| <input type="checkbox"/> Birthmarks                             | <input type="checkbox"/> Combination Skin               |
| <input type="checkbox"/> Melasma / Pregnancy Mask               | <input type="checkbox"/> Laser Treatments               |
| <input type="checkbox"/> Rosacea / Facial Redness               | <input type="checkbox"/> Laser Resurfacing              |
| <input type="checkbox"/> Facial veins / Broken Capillaries      | <input type="checkbox"/> Tattoo removal                 |
| <input type="checkbox"/> Micro-Dermabrasion                     | <input type="checkbox"/> Removing Leg Veins             |
| <input type="checkbox"/> Chemical Peels                         | <input type="checkbox"/> Spider Vein Treatments         |
| <input type="checkbox"/> Sagging / lax skin                     | <input type="checkbox"/> Laser Hair Removal             |
| <input type="checkbox"/> Skin Rejuvenation                      | <input type="checkbox"/> Massage Therapy                |
| <input type="checkbox"/> Photo aged skin                        | <input type="checkbox"/> Triactive/ Cellulite Treatment |
| <input type="checkbox"/> Pore appearance                        | <input type="checkbox"/> Ingrown Hair / Shaving Bumps   |
| <input type="checkbox"/> Skin tone and texture                  | <input type="checkbox"/> Laser Hair Removal             |
| <input type="checkbox"/> Avage <sup>™</sup> , Retin-A or Renova | <input type="checkbox"/> Waxing                         |
| <input type="checkbox"/> Acne                                   |   |
| <input type="checkbox"/> Acne Scars                             |   |
| <input type="checkbox"/> Other, please specify _____            |   |

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PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Effective April 14, 2003, the federal government set a law in place to protect you and the release of your medical information whether it be in written or oral form. Our office is permitted by law not to release protected health information outside of treatment, payment, and healthcare operations without your written consent.

Please list the people (including family members) or companies in which you wish the office of David Vanderpool, M.D. to release your medical records.

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

This request and authorization applies to:

Healthcare information relating to the following treatment,  
condition, or dates of treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ All Healthcare information

I hereby authorize the office of David Vanderpool M.D. to release my protected health information to the above people listed. I understand I have the right go revoke this consent at anytime in writing. I am also aware that this consent is binding and will expire two years from the date of signature.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date of Signature

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LASER AND VEIN ESTHETICS

DATE \_\_\_\_\_

NAME \_\_\_\_\_ SEX: M \_\_\_ F \_\_\_ BIRTHDATE \_\_\_\_\_

CURRENT CONDITION RELATED TO TODAY'S APPOINTMENT:

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ASSOCIATED SYMPTOMS: \_\_\_\_\_

WHAT MEDICAL PROBLEMS HAVE YOU HAD IN THE PAST, OTHER THAN WHAT YOU ARE SEEING THE DOCTOR TODAY?  
THESE MAY BE ACTIVE OR NOT BOTHERING YOU NOW; SOME EXAMPLES: CANCER, COLON PROBLEMS, PNEUMONIA,  
BRONCHITIS, DEPRESSION, MIGRAINES, etc. \_\_\_\_\_

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PAST SURGICAL HISTORY: \_\_\_\_\_

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NAME OF PHYSICIAN WHO REFERRED YOU \_\_\_\_\_

HAVE YOU EVER HAD OR ARE YOU NOW EXPERIENCING ANY OF THE FOLLOWING CONDITIONS?  
(PLEASE CHECK IF YES)

HIGH BLOOD PRESSURE \_\_\_\_\_

HEPATITIS \_\_\_\_\_

DIABETES \_\_\_\_\_

ULCER DISEASE \_\_\_\_\_

HEART PROBLEMS \_\_\_\_\_

VASCULAR DISEASE \_\_\_\_\_

CANCER \_\_\_\_\_

BLOOD CLOTS \_\_\_\_\_

HIV \_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS NOW? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES,  
PLEASE LIST THEM

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DO YOU HAVE ANY ALLERGIES TO MEDICINES? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, PLEASE LIST THEM:

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PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SOCIAL AND FAMILY HISTORY:

DO YOU SMOKE? YES \_\_\_\_\_ NO \_\_\_\_\_ HOW MANY PACKS A DAY? \_\_\_\_\_

DO YOU DRINK? YES \_\_\_\_\_ NO \_\_\_\_\_ HOW MUCH OR HOW FREQUENT? \_\_\_\_\_

HAS ANYONE IN YOUR FAMILY (MOTHER, FATHER, BROTHERS, SISTERS, GRANDMOTHERS,  
GRANDFATHERS) EVER HAD ANY OF THE FOLLOWING CONDITIONS? PUT A CHECK NEXT TO EACH.

HIGH BLOOD PRESSURE \_\_\_\_\_

VARICOSE VEINS \_\_\_\_\_

DIABETES \_\_\_\_\_

CANCER \_\_\_\_\_

HEART PROBLEMS \_\_\_\_\_