PALM AESTHETICS
CENTER FOR PLASTIC AND LASER SURGERY

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

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Patient Name:_____

HISTORY
PLEASE CHECK IF YOU HAVE OR HAVE HAD-

Diabetes _____	Irregular Menses _____	Hepatitis _____
Heart Problems_____	Herpes _____	Hysterectomy _____
Menopause_____	Hypertension_____	Lupus_____
Sensitive to anesthetic _____	Photosensitive disorder _____	Auto Immune _____

Are you under the care of a physician? _____

Current/Recent medications_____

_____

		IF YES EXPLAIN	
Keloid scars	No	Yes	_____
Hives	No	Yes	_____
Skin cancer	No	Yes	_____
Waxing	No	Yes	_____
Electrolysis	No	Yes	_____
Cold Sores	No	Yes	_____
Hypersensitivity to skin products	No	Yes	_____
Skin infections	No	Yes	_____
Tanning w/in the last 6 weeks	No	Yes	_____
Use of acne products/drugs	No	Yes	_____
Laser skin resurfacing	No	Yes	_____
Chemical Peels	No	Yes	_____
Photo sensitizing substances	No	Yes	_____
Laser work of any type	No	Yes	_____

Medical illness _____

Are you pregnant?_____

Allergies of any kind including drugs_____

Areas of interest for aesthetic treatment_____

Requested Areas of Treatment:

BOTOX/XEOMIN	**FILLER**
Frown Lines (between the eyes)_____	Lip augmentation_____
Horizontal forehead lines_____	Nasolabial folds_____
Crow's Feet_____	Marionette lines_____
Bunny lines (bridge of nose)_____	Vertical lip lines_____
Droopy eyebrows_____	Scar fill-in_____

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient signature_____Date_____