Belle Mia Laser Tattoo Removal and Skin Care
Patient Intake Form

Today's Date:

Patient Information:

Sex: □ Male □ Female DOB: _____ Age:_____
Title: _____ First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Work #: _____ Mobile #: _____
Email: _____

Employment Information:

Patient Employer: _____ Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip: _____
Work phone No: _____ Ext. _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____
Patient's Spouse: _____ Phone: _____
Family Physician: _____ Phone: _____

Medical History

Are you pregnant? □Yes □ No
Breastfeeding? □Yes □ No
Do you have allergies? □Yes □ No
If so, please list: _____
Are you currently under the care of a physician? □Yes □ No
If yes, for what:_____
Are you currently under the care of a dermatologist? □Yes □No
If yes, for what:_____

Medications

What medications are you presently taking? □Birth control pills □Hormones □Prescription
□Others (Please list): _____
Are you on any mood altering or anti-depression medication?_____
Have you ever used Accutane? □Yes □No If yes, when did you last use it?_____
What topical medications or creams are you currently using? □ Retin-A®
□Others (Please list): _____
What supplements do you use regularly?_____
Have you ever had an allergic reaction to any of the following? (Check all that apply and describe your reaction)
□Food _____
□Latex _____
□Aspirin _____
□Lidocaine _____
□Hydrocortisone _____
□Hydroquinone or skin bleaching agents _____
□Others:_____

Examinations:
Date of last physical examination _____ Reason _____
Hospitalizations _____ Dates _____ Reasons _____
X-Rays: Chest _____Stomach ____ Gallbladder _____ Kidney ____Colon ____ Others _____
Electrocardiogram (heart tracing) _____ Laboratory tests: _____
Date of last pap (cancer smear): _____

Do you now have or have had any of the following? (circle)

Itching	Eczema	Hives	Joint Pains	Muscle Aches
Arthritis	Limitation of Motion	Backache	Leg Pains	Heel Pains
Neck Pain/Stiffness	Goiter	Enlarged Glands	Lung Disease	Heart Trouble
High Blood Pressure	Chest Pain	Jaundice	Asthma	Chicken Pox
Shortness of Breath	Palpitation/Fluttering	Lips/Nails Turn Blue	Tire Easily	Ankle Swelling
Gas or Bloating	Abdominal Pain	Constipation	Colitis	Hemorrhoids
Bleeding/Black Stool	Hernia	Urinary Pain	Kidney Disease	Bladder Disease
Kidney Stones	Stroke	Incontinence	Pus/Blood in Urine	Herpes
Nervousness/Anxiety	Depression	Paralysis	HIV/AIDS	Varicose Veins
Insomnia	Fainting	Thyroid Problems	Tuberculosis	Seizures
Headaches	Convulsions	Menopause	Hepatitis	Freq. Cold Sores
Keloid Scarring	Infections	Measles	Mumps	Blood Clots
Skin Disease/Lesions	Seasonal Allergies	Scarlitina	Diptheria	Polio
Hormone Imbalance	Birth Defects	Influenza	Rheumatic Fever	Pneumonia

Diabetes:Type: _____ Cancer: Type: _____
Other Diseases _____
Surgeries:(dates) _____

Please make any comments that you think might be helpful:

_____
_____

Do you currently have any medical concerns? Please List: _____
_____

Skincare:
Which of the following best describes your skin type? (Please circle one type number)

I	Always burns, never tans
II	Always burns, sometimes tans
III	Sometimes burns, always tans
IV	Rarely burns, always tans
V	Brown, moderately pigmented skin
VI	Black skin

Do you regularly use tanning salons or sun bathe?_____How often?_____

*****Should you need to cancel, please contact us 24 hours in advance of your scheduled appointment. All cancellations with less than 24 hours' notice will result in full charges to your card, or a deduction to your gift certificate. This courtesy enables us to compensate our employees for their time, and maintains a higher availability of our time for you as well as others. By scheduling an appointment, you are agreeing to our cancellation policy. Late arrivals may result in a shortened appointment.*****

How did you hear about us? Please check all that apply

_____Our website _____Facebook _____ Friend Other_____

If you were referred by someone, please tell us who referred you _____

Financial Policy:
Thank you for selecting Belle Mia Laser Tattoo Removal and Skin Care for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. **WE DO NOT ACCEPT CHECKS**.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

_____ _____
Patient's Signature Date