Laser Solutions Medical Spa

MEDICAL HISTORY FORM

Weight Loss Center of Arkansas

Today's Date _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Place of Employment: _____ Work Phone: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

How would you like to be addressed? ☐ Male ☐ Female ☐ Other: _____

How did you hear about us, or whom may we thank for referring you to Laser Solutions Med Spa & Weight Loss Center of AR? _____

Primary Physician Name: _____ Phone: _____

Pharmacy: _____ Phone: _____

Allergies: ☐ Penicillin ☐ Morphine ☐ Dye ☐ Pets ☐ Codeine ☐ Aspirin ☐ Nitrate ☐ Sulfa Drugs

☐ Seasonal (pollen) ☐ Food ☐ No Known Allergies

Please describe the allergic reaction you experienced and when it occurred: _____

	Yes	No	How much & how often:	Last date of use:
Do you use tobacco?				
Do you use alcohol?				
Do you use caffeine?				

Check any of the following that you are currently taking or have taken in the past 30 days:

☐ *Aspirin* ☐ *Accutane* ☐ *Ibuprofen* ☐ *Aleve* ☐ *Plavix* ☐ *Vitamin E*

List other current medications: _____

List all supplements: _____

Have you ever had an adverse reaction to anesthetic (e.g., dentist)? ☐ *Yes* ☐ *No*

WOMEN Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ *Yes* ☐ *No* Date of last menstrual period? _____

Do you have, or have you ever had, any of the following medical conditions?

	Yes	No	Explain
Heart condition			
High blood pressure			
Circulation problems			
Diabetes			
Fainting/dizziness			
Stroke			
Cancer			
Herpes (cold sores)			
Asthma/COPD			

Bleeding disorders			
Menopause symptoms			
Visual problems			
Chemotherapy/Radiation			
Neurological disorder			
Autoimmune disorder			
Chronic infections			
Kidney problems			
Stomach ulcer/gastritis			
Chronic headaches			
Gallbladder problems			
Prosthetic placement (total hip/knee procedure)			
Pacemaker			
Intertrochlear Implant			
Spinal Stimulator			

Please list major surgeries, and approximate date: _____

INJECTION AND LASER ADDENDUM

Check any of the following that you are currently taking or have taken in the past 30 days:

☐ *Retin A* ☐ *Tazorac* ☐ *Avage* ☐ *Prevage* ☐ *Retinol* ☐ *C+E Ferulic*

List any other skin care product: _____

Have you had any of the following treatments, procedures, or surgeries?

	Yes	No	Explanation
Neuromodulator (Botox, Xeomin)			
Derma Filler			
Chemical Peels			
Laser Treatment			
Liposuction			
Face or Neck life			
Blepharoplasty (eye lift)			
Breast augmentation			
Abdominoplasty (tummy tuck)			
Other cosmetic procedures			

_____ _____

Signature Date

_____

Print Name

REFUND & LATE POLICY

initial

_____ I understand that Laser Solutions Medical Spa /Weight Loss Center of Arkansas offers no refunds on any procedure. If you choose not to have a procedure, you may have a credit at the clinic for any service of equal value.

_____ I understand arriving to my appointment more than 10 minutes after the scheduled time will result in needing to reschedule for another day.

_____ I understand that after three (3) no-show appointments I will have to pay in advance before any future appointments will be scheduled.

_____ I understand that any no-show appointments for prepaid package session will result in the loss of that session.

_____ I understand that I will receive a text confirming my appointment 1-2 days before this time slot and I must reply with "C" to confirm. If I do not confirm this appointment within 24 hours of my appointment, I understand that my appointment slot may be reassigned to another patient.

CONSENT & AUTHORIZATION TO USE PHOTOS & IMAGES

I authorize Laser Solutions Medical Spa/Weight Loss Center of Arkansas to use, reproduce, alter, publish, and publicly display all photographs, videos, and other images of me that may be taken or produced. Laser Solutions Medical Spa may use them for patient education, patient information, staff training, medical education, marketing, and other purposes and may use them in or on publications, educational materials, marketing materials, broadcast media, television advertising, other advertising media, and electronic media (including social media), whether commercial or noncommercial, for an unlimited period. Among other uses, Laser Solutions Medical Spa may use and display the photos, videos, and images in materials, media, and presentations to provide or display "before and after" treatment information. The manner of use will be determined solely by Laser Solutions Medical Spa, and I will not have any right to inspect or approve the use of any associated materials or publications. I will not be entitled to receive any compensation or payment from Laser Solutions Medical Spa for this authorization and any use. This consent and authorization are irrevocable.

I understand that when using the photos, videos, or other images, Laser Solutions Medical Spa may include my first name or a fictitious name, but will not include other identifying information, such as my address, email address, or phone number. Also, Laser Solutions Medical Spa may in its discretion use only a portion of photos, videos, and images and may crop them before publishing, presenting, or displaying them. I represent that I am 18 years of age or older.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have received a copy of the Notice of Privacy Practices.

_____ _____

Signature Date

_____

Print Name

FOR CLINIC USE ONLY: Russell S. Gornichec, MD, PC., made the following good faith efforts to obtain the above referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices (Identify the efforts that were made to obtain the individual's written acknowledgment, including the reasons, if known, why the written acknowledgment was not obtained.)