Renew
LASER & AESTHETICS

NEW PATIENT REGISTRATION

FIRST NAME_____ LAST NAME_____

STREET ADDRESS_____ APT#_____ CITY_____ STATE _____ ZIP_____

HOME PHONE_(_____)_____ CELL PHONE_(_____)_____

DATE OF BIRTH_____(mm/dd/yyyy) E-MAIL ADDRESS_____

EMERGENCY CONTACT NAME_____ RELATIONSHIP_____

EMERGENCY CONTACT PHONE_(_____)_____WHAT IS YOUR OCCUPATION? _____

IS THIS YOUR FIRST VISIT TO OUR OFFICE? __YES __NO IF YES, WHO REFERRED YOU? _____

WHAT SPECIAL AREAS OF CONCERN DO YOU HAVE? PLEASE CHECK ALL THAT APPLY.

__ACNE MANAGEMENT	__ENLARGED PORES	__SKIN REJUVENATION
__ACNE SCARRING	__FINE LINES & WRINKLES	__SURGICAL SCARRING
__AGE SPOTS	__HAIR REMOVAL	__STRETCH MARKS
__BROKEN CAPILLARIES	__PIGMENTATION	__SUN DAMAGE

__OTHER_____

HAVE YOU EVER HAD COSMETIC TREATMENTS? __YES __NO

WHICH BEST DESCRIBES YOUR SKIN TYPE?

__ALWAYS BURNS, NEVER TANS	__RARELY BURNS, ALWAYS TANS
__ALWAYS BURNS, SOMETIMES TANS	__BROWN, MODERATELY PIGMENTED SKIN
__SOMETIMES BURNS, ALWAYS TANS	__BLACK SKIN

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? PLEASE CHECK ALL THAT APPLY:

ARTHRITIS	__YES	__NO	HIGH BLOOD PRESSURE	__YES	__NO
BLOOD CLOTTING ISSUES	__YES	__NO	HIV/AIDS	__YES	__NO
CANCER	__YES	__NO	HORMONE IMBALANCE	__YES	__NO
DIABETES	__YES	__NO	KELOID SCARRING	__YES	__NO
FREQUENT COLD SORES	__YES	__NO	HEPATITIS	__YES	__NO
HERPES	__YES	__NO	THYROID IMBALANCE	__YES	__NO
SEIZURE DISORDERS	__YES	__NO	ARE YOU PREGNANT?	__YES	__NO

HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY:

__ASPIRIN	__LATEX	__HYDROCORTISONE	__ALOE VERA
__LIDOCAINE	__SKIN BLEACHING AGENTS	__HYDROQUINONE	

WHAT ORAL MEDICATION(S) ARE YOU CURRENTLY TAKING? _____

_____

ARE YOU ON ANY MOOD ALTERING OR ANTI-DEPRESSION MEDICATION? YES ___ NO ___

HAVE YOU EVER USED ACCUTANE? YES ___ NO ___ IF YES, WHEN? _____

ARE YOU CURRENTLY USING RETIN-A OR RETINOLS? YES ___ NO ___

WHAT TOPICAL MEDICATIONS ARE YOU CURRENTLY USING? _____

HAVE YOU EVER HAD LASER HAIR REMOVAL IN THE PAST? YES ___ NO ___

WHAT HAIR REMOVAL METHODS HAVE YOU USED IN THE PAST SIX (6) WEEKS?

___ WAXING	___ ELECTROLYSIS	___ TWEEZING	___ THREADING
___ DEPILATORIES	___SHAVING	___ LASER	

Renew
LASER & AESTHETICS

CONSENT FOR ALEXANDRITE OR Nd:YAG LASER THERAPY

PATIENT: _____ I am aware that Alexandrite or NdYAG laser treatment is utilized for hair removal and/or photo facials. I understand the nature, goals, limitations and possible complications of this procedure. I have had the opportunity to ask questions about the procedure, it's limitations and possible complications (see below).

I clearly understand and accept the following: 1. The goal of the laser treatment, as any cosmetic procedure, is improvement and not perfection. I understand my result might not be perfect. In the case of Lasertrolysis (removing hair using a laser), and/or photo facials the number of necessary treatments is dependent on several factors including skin color, tan and hair color. 2. There may be more treatments necessary than I anticipated. 3. The Alexandrite and NdYAG lasers have shown that they can reduce hair permanently or cause profound hair growth delay, but results will definitely vary from person to person. 4. The treatment fees have been discussed with me and I understand them. The fee at the time of service is for that procedure only. There will be a charge on all subsequent procedures. 5. There is no guarantee that the expected or anticipated results will be achieved. 6. I authorize the use of any photographs taken for teaching and other viewing purposes.

The Alexandrite and NdYAG laser pose an acceptably low risk of complications. As of March 1998, treatment with the Alexandrite or NdYag lasers has caused no significant complications to occur; however, side effects most certainly will occur as more and more patients are treated. Tests and studies are ongoing regarding laser-induced hair removal. Although complications seem to be infrequent following Alexandrite, NdYAG laser-induced hair removal, I understand the following side effects of complications may occur, and I understand that compliance with aftercare guidelines are critical to healing, prevention or scarring, and hyper/hypo pigmentations, and/or are theoretically possible with the Alexandrite and NdYAG laser and could happen to me.

1. Discomfort at the treatment site with transient redness and possible some edema (swelling). 2. Decrease (hypo) or increase (hyper) in pigmentation typically lasting 1-3 months, however it may take 3-6 months to heal. 3. Loss of pigmented lesions such as freckles which may give the appearance of a loss of pigment. 4. Activation of cold sores (we try to minimize this by giving you medication before your laser treatment which has been very effective with other laser treatments. 5. Folliculitis (inflammation of the hair follicle). 6. Scars or loss of pigment will probably occur at some low frequency, although the incidence is not available yet because these problems have not yet been encountered. This can be attributed to the fact that large numbers of patients have not had this treatment yet. 7. Small blister and/or crusting. 8. Redness after treatment for about 2 days. 9. The laser center, medical staff and specific technicians will not be held liable if any of the above occurs.

_____	_____	_____
Patient's Signature	Print Patient Name	Date

_____	_____	_____
Technician Signature	Print Technician Name	Date

9910 FL Alternate A1A, Suite 10, Palm Beach Gardens, FL 33410
renewlaserofpalmbeach.com (561) 255-0272
Medical Director: Joan Baijnath, MD of eMDe Cares

I acknowledge that the practice of skin care and massage including microdermabrasion, electrolysis, facial and body treatments, laser treatments, tattoo removal, vein treatments, brown spot removal, BOTOX, Juvederm, Dermal Fillers and various other beauty or health procedures are not an exact science and no specific guarantees can or have been made concerning the expected results. I understand that some patients experience more change and improvements than others. In virtually all cases, multiple treatments are required in order to realize a difference.

I also understand that the following risks and hazards may occur in connection with any particular treatment including but not limited to: unsatisfactory results, poor healing, discomfort, redness, bruising blistering, nerve damage and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to hold harmless and release from any liability Renew Laser & Aesthetics, eMDe Cares, as well as any technicians, doctors or employees of the above companies for any condition or results known or unknown that may arise as consequence of any treatment I receive.

_____	_____	_____
Patient's Signature	Print Patient's Name	Date
_____	_____	_____
Technician's Signature	Print Technician's Name	Date

24-Hour Cancellation Policy:

Renew Laser & Aesthetics is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. Please call us at (561) 255-0272 twenty-four (24) hours prior to your scheduled appointment to notify us of any changes or cancellations. Patients who do not give prior notice, do not confirm their appointment or are considered "No Show" are charged the full amount of the service.

_____	_____	_____
Patient's Signature	Print Patient's Name	Date

Acknowledgement of Receipt Notice of Pre and Post Treatment

This is to acknowledge that Post Treatment instructions for Laser Hair Removal or Photo Facial are received on the date stated below.

_____	_____	_____
Patient's Signature	Print Patient's Name	Date
_____	_____	_____
Technician's Signature	Print Technician's Name	Date