



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.

<input type="checkbox"/> ACNE MANAGEMENT	<input type="checkbox"/> ENLARGED PORES	<input type="checkbox"/> SKIN REJUVENATION
<input type="checkbox"/> ACNE SCARRING	<input type="checkbox"/> FINE LINES & WRINKLES	<input type="checkbox"/> SURGICAL SCARRING
<input type="checkbox"/> AGE SPOTS	<input type="checkbox"/> HAIR REMOVAL	<input type="checkbox"/> STRETCH MARKS
<input type="checkbox"/> BROKEN CAPILLARIES	<input type="checkbox"/> PIGMENTATION	<input type="checkbox"/> SUN DAMAGE
<input type="checkbox"/> OTHER _____		

HAVE YOU EVER HAD COSMETIC TREATMENTS? __YES __NO

WHICH BEST DESCRIBES YOUR SKIN TYPE?

<input type="checkbox"/> ALWAYS BURNS, NEVER TANS	<input type="checkbox"/> RARELY BURNS, ALWAYS TANS
<input type="checkbox"/> ALWAYS BURNS, SOMETIMES TANS	<input type="checkbox"/> BROWN, MODERATELY PIGMENTED SKIN / MODERATE MELANIN
<input type="checkbox"/> SOMETIMES BURNS, ALWAYS TANS	<input type="checkbox"/> BLACK, DEEPLY PIGMENTED SKIN / HEAVY MELANIN

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

ARTHRITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIGH BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO
BLOOD CLOTTING ISSUES	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIV/AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO
CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO	HORMONE IMBALANCE	<input type="checkbox"/> YES <input type="checkbox"/> NO
DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO	KELOID SCARRING	<input type="checkbox"/> YES <input type="checkbox"/> NO
FREQUENT COLD SORES	<input type="checkbox"/> YES <input type="checkbox"/> NO	HEPATITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO
HERPES	<input type="checkbox"/> YES <input type="checkbox"/> NO	THYROID IMBALANCE	<input type="checkbox"/> YES <input type="checkbox"/> NO
SEIZURE DISORDERS	<input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU PREGNANT?	<input type="checkbox"/> YES <input type="checkbox"/> NO

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

<input type="checkbox"/> ASPIRIN	<input type="checkbox"/> LATEX	<input type="checkbox"/> HYDROCORTISONE	<input type="checkbox"/> ALOE VERA
<input type="checkbox"/> LIDOCAINE	<input type="checkbox"/> SKIN BLEACHING AGENTS	<input type="checkbox"/> 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?

<input type="checkbox"/> WAXING	<input type="checkbox"/> ELECTROLYSIS	<input type="checkbox"/> TWEEZING	<input type="checkbox"/> THREADING
<input type="checkbox"/> DEPILATORIES	<input type="checkbox"/> SHAVING	<input type="checkbox"/> LASER	



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 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. 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



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



LASER HAIR REMOVAL PRE & POST INSTRUCTIONS

It is crucial to the health of your skin and the success of your treatment that these guidelines are followed.

PRE TREATMENT INSTRUCTIONS

Avoid tanning of any kind for at least 2 weeks prior to treatment. This includes sun, tanning bed and any form of self-tanning (i.e. lotion sprays and foams). The Alexandrite Laser is specifically attracted to pigment. Sun exposure, resulting in a tan, tanning bed or self-tanning may result in a burn, hyperpigmentation (darkening of the area) or hypopigmentation (loss of pigment). This is typically a temporary reaction, but may take several months for your skin to return to its normal state.

Stop bleaching, waxing, tweezing or using any depilatories 3 to 4 weeks prior to treatment and avoid completely during treatment. You may shave the area.

Stop the use of retinol or Retin-A 3 to 5 days prior to your treatment.

Discuss any photosensitive medications you are taking with your technician.

Refrain from laser treatment during the course of antibiotics. You may resume laser treatments 2 weeks after your very last dosage.

Use sunscreen with SPF 30 or higher daily. Apply 20 minutes prior to sun exposure and reapply every 80 minutes when in the sun. When swimming or sweating, reapply every 40 minutes. This rule applies to pre and post laser treatment.

POST PROCEDURE INSTRUCTIONS

Avoid excessive sun exposure in the treated area 10 to 14 days post laser treatment.

Shortly after treatment, it is common to experience bumps, redness and swelling (edema and erythema) in the treated area. These symptoms are normal and should subside within 2 hours. Aloe Vera or Post Laser Lotion may be applied to help soothe the treated area after treatment.

Keep the area clean, cool and dry. When bathing within the first 48 hours, you may cleanse the treated area with tepid to cool water and mild or antibacterial soap. Gently pat dry with a clean towel.

Avoid heat and or rubbing as this can irritate the treated area.

Avoid excessive sweating for 48 hours. Sweating introduces bacteria to the treated hair follicles. This could cause irritation (inflammation / folliculitis) in the area.

Avoid exercise, swimming pools and or any activity that could potentially introduce bacteria into the follicles as this may cause irritation and/or infection to the treated area.

Avoid tight clothing, scratching, rubbing or scrubbing the area 48 hours after your treatment. Blisters, oozing and scabs may appear in sensitive areas (i.e. bikini) within one to two days. Do not pick or remove scabs. Topical ointment can be applied (Bacitracin or Bactroban) to the affected area twice daily. Do not be alarmed, but do feel free to call your technician with any concerns.

Some patients may experience a histamine reaction. If this occurs, you can use Benadryl or Hydrocortisone to relieve the itching.

You may shave 72 hours after treatment to promote shedding. The hair that was targeted by the laser will purge from the follicle and this will look as if it is continuing to grow. This is called the Shedding Process and should stop within 10 to 21 days following treatment.

Should you have any questions, please do not hesitate to call 561-255-0272 or email info.renewlaser@gmail.com



PHOTO REJUVENATION PRE AND POST PROCEDURE INSTRUCTIONS

It is crucial to the health of your skin and the success of your treatment that these guidelines are followed.

PRE TREATMENT INSTRUCTIONS

Avoid sun exposure (apply sunscreen daily and do not tan at all – including self-tanner) for 4 to 6 weeks before and after treatments.

Do not use any retinol products (or products containing tretinoin) or exfoliants on the area to be treated 3-5 days.

Avoid Accutane (or isotretinoin products) for six (6) months prior.

If taking Photosensitive medications like Antibiotics, treatment may begin two (2) weeks after your very last dosage.

Anticipate a social "down-time" of 2 – 5 days before any redness, swelling and sloughing of the sunspots has subsided.

Come to your appointment with a clean face. Remove all makeup if the area to be treated is the face. The area to be treated must be clean, dry and free of any oils, lotions, creams or makeup.

POST TREATMENT INSTRUCTIONS

You may have a mild "sunburn" (burning) sensation following the treatment that is usually gone within a few hours. Skin redness is normal and may last a few days. There may be a slight amount of swelling. Blistering is uncommon and not serious.

Pigmented areas may begin to flake after a few days. Cold compress may be useful for the first 24 hours.

Your skin will be fragile for 2-3 days. Use a gentle cleanser, do not rub the skin and avoid hot water during this time. Gently pat skin dry after cleansing.

Do not use Clarisonic or a loofah for one (1) week.

Do not use any retinoids, tretinoin, alpha or beta hydroxy products, vitamin C products, scrub, exfoliate or have chemical peels performed on the treated area for one (1) week. Mineral Makeup can be applied immediately (if the skin is not broken).

Avoid the sun or excessive sun exposure in the treated area and use sun block. Avoid excessive heat or friction to the treated area (hot water, heavy exercise, saunas) or any activities that can introduce bacteria into the area, such as swimming pools, hot tubs, etc.

Sun spots and age spots will DARKEN with the GentleLASE treatment BEFORE they begin to respond and resolve. This is expected and a normal part of the Photo Rejuvenation process. Do not pick these spots once they become dry. They will lift and fall off on their own.

Please contact (561) 255-0272 as soon as possible if you experience any blistering, increased pain or if you are concerned about infection.



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.

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



SCHEDULING POLICY

CREDIT CARD REQUIRED

Renew Laser & Aesthetics requires a valid credit card on file to schedule all services. All card information is stored within the encrypted, secure Square payment processing system. Once entered, card information is not visible to any party except the processor. Aside from specific services that require a deposit, nothing will be charged upon booking and a different card may be used to pay for services when they are rendered.

CREDIT CARD AUTHORIZATION

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

CREDIT CARD INFORMATION

Card Type: ___MASTERCARD ___VISA ___DISCOVER ___AMEX

OTHER_____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

Cardholder ZIP Code (from credit card billing address):_____ CVV Code:_____

I, _____, authorize Renew Laser & Aesthetics, LLC. to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature

Date

24-HOUR CANCELLATION POLICY

Once your appointment is scheduled, you will receive an automated text message forty-eight (48) hours in advance to confirm your appointment. Please respond to this text message to confirm or cancel no later than twenty-four (24) hours prior to your appointment. Unconfirmed appointments are forfeited. No Shows / Appointments canceled in less than twenty-four (24) hours will be charged a \$50 fee and must be paid before another appointment can be scheduled.

Patient's Signature

Print Patient's Name

Date