U Laser Med Spa & Umansky Plastic Surgery

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A Medical Corporation

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A Medical Corporation

PATIENT NAME (LAST, FIRST, MI, MAIDEN):_____

HOME ADDRESS:_____
(STREET) (CITY) (ZIP)

PHONE (CELL): _____(HOME)_____(WORK)_____

SEX: (M / F) DATE OF BIRTH:_____ AGE:_____MARITAL STATUS: M S W D SEP
OF CHILDREN _____

PATIENT EMAIL ADDRESS:_____PATIENT SSN #:_____

SPOUSE/PARENT NAME:_____MAY WE CONTACT YOU VIA EMAIL: YES / NO

EMERGENCY CONTACT:_____ PHONE:_____
RELATIONSHIP TO PATIENT:_____ EMAIL:_____

REFERRED BY:_____

WHAT ARE YOUR AREAS OF CONCERN?

_____Dermal fillers (Juvederm, Voluma)
_____Botox/DysportLaser hair removal
_____Laser skin rejuvenation
_____Vein treatments (Laser, sclerotherapy)
_____Laser tattoo removal
_____Viveve – Vaginal Rejuvenation
_____IPL (brown spots)
_____Laser scar treatment
_____Facials/Chemical Peels
_____Dermal Infusion
_____MicroNeedling
_____CoolSculpting for fat reduction
_____Pelleve for skin tightening (radio frequency)

Are you a member of Brilliant Distinctions rewards program? _____Yes _____No, Sign me up

MEDICAL HISTORY (WITHIN THE LAST 5 YEARS)

PRIMARY CARE PHYSICIAN:_____
MEDICATIONS/DRUGS/VITAMINS CURRENTLY TAKING:_____
ALLERGIES TO ANY MEDICATIONS:_____
LATEX ALLERGY OR LATEX SENSITIVITY: YES_____ NO_____
PREVIOUS SURGERIES/HOSPITALIZATIONS:_____
DO YOU SUFFER FROM: HIGH BLOOD PRESSURE_____ HEART DISEASE_____
DIABETES_____ANY CHRONIC ILLNESS_____ OTHER CONDITION_____
GENERAL HEALTH: GOOD_____FAIR_____POOR_____
DO YOU SMOKE?_____HOW MUCH?_____
Pregnant/Breastfeeding: Y or N Fever blister/Cold Sore Y or N Autoimmune Disease Y or N Keloid Scarring Y or N

Each patient (or responsible party) is financially responsible for services rendered. While we are pleased to assist in the preparation of submission of insurance forms, the obligation of payment remains that of the patient (responsible party). I authorize the release of any medical information necessary to process this claim. I understand I am financially responsible for the unpaid balance of all accounts in the event this authorization is insufficient to liquidate this account. I hereby assign and transfer any insurance benefits paid to me for professional services to be paid directly to the physicians. We have a no show & 48 hour late cancellation policy. In the event of a late cancellation or no show, your credit card on file will be charged a $50 fee. This fee cannot be applied toward any services. Should you have any questions regarding fees or terms, please do not hesitate to ask.

X_____ _____
Signature of patient, responsible party or legal guardian DATE

Good Faith Exam _____ _____
Provider Initials Date Completed