New Patient Information

Name: ___________________________ Birth Date: _______________ Age: _______
Address: ____ Sex: M / F
City: _______________________________ State: __________ Zip Code: __________
Home: _______________________ Work: ___________________ Cell: ___________________
E-Mail: ____
Emergency Contact: _____________________________Telephone: _____________________________
Allergies: ____
How did you hear about Mecca Integrated Medical Center? ____________________________________

Please put a check mark next to the procedures which you would like to receive more information:

___Acne Treatment
___Botox
___Enhanced Skin Rejuvenation
___Collagen Augmentation
___Wrinkles
___Skin Toning or Pore Size Reduction
___Facial Redness
___Brown Spots
___Sun Damage
___Broken Capillaries
___Spider Veins/Leg Veins
___Hair Reduction
___Shaving bumps/ingrown hair

Please put a check mark next to a past or current medical condition:

___Lupus or other auto-immune deficiency
___Pregnancy
___Bleeding abnormalities
___Treatment with Accutane in the last year
___Treatment with Tetracycline in the past month
___Keloid or very thick scarring
___Psoriasis or Vitiligo
___Epilepsy
___Scars that turn white or brown
___Dark spots after pregnancy, skin injury
___HIV
___Hepatitis
___Pulmonary embolism/blood clot
___Leg ulcer or Phelbitis
___Blood thinning medication
___Coumadin anti-clotting agents
___Rheumatoid Arthritis “Gold” Therapy
___Cystic Acne
___Herpes simplex or fever blisters
___Diabetes
___Waxing/Plucking/Electrolysis within the last four weeks
___Hirsutism
___Transplant Anti-Rejection Drugs
___Chemical Peels, Dermabrasion, Laser Resurfacing or Face Lift

Please list any medication or herbal supplements that you are currently taking:
____
____

Patient Signature: ____ Date: ______________

PATIENT CONSENT FOR LASER HAIR REMOVAL TREATMENT

My signature below constitutes my acknowledgment that I, ___________________________, am a competent, consenting adult of at least 18 years of age (or my parent or legal guardian is giving consent on my behalf) and further, that I:

- Have read and understand the information provided in this form;
- Have had my procedure adequately explained to me by my clinician;
- Have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction;
- Have received all of the information I desire concerning my procedure;
- Consent to photographs of the treatment area;
- Understand all post treatment recommendations and agree to adhere to them;
- Freely assume any risks of complications or injury from known or unknown causes associated with, relating to, or otherwise arising out of this procedure;
- Have the right to consent to or refuse any proposed procedure at any time prior to its performance;
- Must notify the clinician if my medical history changes prior to subsequent treatments;

Consent to, and authorize the Doctor to perform the laser treatment for _________________________.

____ ____________________

Signature (Patient, or if under 18, signature of legal parent/guardian) Date

Printed name of signatory: ____

If signed by other than patient, indicate relationship: ____

Witness: ____ Date: ____________________

Laser Hair Removal/Pseudo Folliculitis

The laser system is designed to target and destroy the hair follicle. The procedure involves shaving the hair from the treatment area. A topical anesthetic may be applied to reduce discomfort associated with laser treatment. Photographs of the treatment area may be taken for your chart and future comparison.

Possible benefits of this treatment are delayed re-growth of the hair, lightening of the hair, decreased density of the hair and long term or permanent reduction in the number of hairs growing in the treatment areas. Multiple treatments are required to achieve hair removal. Short-term redness and some edema may be expected.

Possible risks or discomforts (side effects) may include pain, burning, blister formation, and stinging sensation, infection, pigmentary changes including decrease or increase in skin color at the site of treatment, scar formation , laser induced “cold-sore-like” blistering, skin eruptions known as “herpetic” skin eruptions at the site of treatment and poor cosmetic outcome. Recurrence of hair growth at treatment sites is also a possibility.

GENERAL RISKS

Eye injury due to use of the laser is a risk to the patient and to the clinician, however, the risks are almost completely eliminated with the use of proper eyewear.