CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name_____Today's Date_____

Date of Birth_____Age_____Occupation_____

Home Address_____City_____State___Zip Code____

Home Phone (___)_____Work Phone (____)_____

Emergency Contact Name and Phone_____

How were you referred to us? _____

DENTAL HISTORY

Are you currently under the care of a dentist or physician? ☐ Yes ☐ No

If yes, for what:_____

Do you have any of the following dental or medical conditions? (Please check all that apply)

☐ Amalgam or Gold Fillings ☐ Composite Fillings ☐ Porcelain (Ceramic) Dental Materials

☐ Veneers ☐ Unfilled Cavities ☐ Crowns ☐ Periodontal Disease ☐ Chipped or Warn Teeth DHIV/AIDS ☐ Herpes/Fever Blisters or Cold Sores ☐ Any active infection

Do you have any other dental problems or medical conditions? Please list: _____

_____

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) ☐ Food ☐ Latex ☐ Aspirin ☐ Lidocaine ☐ Hydrocortisone ☐ Hydroquinone or skin bleaching agents ☐ Others**:**_____

_____

MEDICATIONS

What oral medications are you presently taking? ☐ Birth control pills ☐ Hormones

☐ Others (Please list): _____

For our female clients: Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

I certify that the preceding medical, personal and dental history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____Date:_____