**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: