

Main Line Center for Laser Surgery
32 Parking Plaza, Suite 200
Ardmore, PA 19003

NAME _____
(Last) (First) (Middle)
SS# _____ BIRTHDATE _____ SEX: M F MARITAL STATUS: S M D W

HOME ADDRESS _____
(Street) (Apt) (City) (State) (Zip)

HOME PHONE _____ E-MAIL _____

WORK PHONE _____ CELL PHONE _____

OCCUPATION _____ EMPLOYER NAME _____

REFERRED BY PHYSICIAN FRIEND INTERNET OTHER _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE# _____

Specialized Care

I understand that the Main Line Center for Laser Surgery is a tertiary referral practice. The physicians at our center will evaluate the specific problem for which you have been referred or have sought treatment. General dermatologic care and evaluation is the responsibility of the referring or primary physician. If you require a referral to a general dermatologist, please notify our office.

(Sign Name) (Date)

Reason for visit _____

Name of General Dermatologist _____

Have you ever been on Accutane? YES NO If yes please also inform the doctor verbally. When? _____

Do you have or have a history of Cold Sores? NO YES

Do you have or have a history of Scarring or Keloids? NO YES

Do/have you ever had permanent makeup/tattoos? NO YES If yes please also inform the doctor verbally

If yes where? Eyebrows Eyeliner Lip liner Other _____

Have you ever had Gold Therapy? NO YES If yes please also inform the doctor verbally

Are you pregnant at this time? NO YES

Do you faint when having blood drawn? NO YES

SOCIAL HISTORY: (CHECK ALL THAT APPLY)

Do you smoke? NO YES - Frequency _____ Do you use recreational drugs? NO YES - Frequency _____

DRUG ALLERGIES: (LIST TYPE OF REACTION) _____

NON-DRUG ALLERGIES: LATEX OTHER (SPECIFY) _____

PRESENT/PAST MEDICAL HISTORY: (LIST CONDITIONS AND DATE) _____

ARE YOU CURRENTLY TAKING MEDICATION? YES NO IF SO, PLEASE LIST: _____

SURGICAL HISTORY: (LIST TYPE, REASON FOR SURGERY, DATE, SURGEON) _____

PERSONAL or FAMILY HISTORY of MELANOMA? YES NO WHO? _____

CANCER(S): (LIST TYPE, DATE, TREATMENT) _____

INFECTIOUS: _____ HIV Positive _____ AIDS Virus _____ Hepatitis _____ Other, specify _____

INTEGUMENTARY: _____ Psoriasis _____ Eczema _____ Cystic Acne _____ Loss of Pigment _____ Other, specify _____

MUSCULOSKELETAL: _____ Arthritis _____ Lupus _____ Joint pain _____ Joint replacement _____ Cold sensitivity _____ Other, specify _____

CARDIOVASCULAR: _____ Stroke _____ Palpitation _____ Pacemaker _____ High blood pressure _____ Other, specify _____

NEUROLOGICAL: _____ Headaches _____ Convulsions _____ Seizures _____ Epilepsy _____ Memory loss _____ Other, specify _____

ALLERGIC/IMMUNOLOGIC: _____ Asthma _____ Frequent infections _____ Allergies _____ Thyroiditis _____ Vitiligo _____ Other, specify _____

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OUR CANCELLATION POLICY

We do understand that there are times when you are unable to keep an appointment and need to reschedule. We ask that you kindly advise us at least 24 hours in advance. This will enable us to fill the appointment slot with someone from our wait list, and you will NOT be charged.

However, if you cancel an appointment within 24 hours or fail to show up for an appointment, you will be required to pay in full to make a future appointment. If you subsequently fail to provide adequate notice or fail to show up again, your payment will be held and NOT refunded and NOT put towards future appointments.

Thank you in advance for your cooperation.

Patient Signature

Date

