FINE-LIGHT/ACU-CLEAR PATIENT INFORMATION

Name: _____Email:_____
Last First

Address: _____
City State Zip

Social Security No:_____ Age:_____ Birth Date:_____

Employer:_____ Occupation: _____

Home #: _____ Business #: _____ Cell #_____

Whom may we thank for referring you to our office?: _____

Emergency Contact: _____ Contact #: _____

Family Doctor: _____ Address: _____

Doctor Phone: _____

Please check any conditions you currently have or have been treated for in the past.

___ Kidney/Liver Disease
___ Cardiac Arrhythmias or Heart Disease
___ Cancer
___ Pregnancy
___ Medical Edema
___ Auto Immune Disease
___ Thyroid Problems
___ Urine Infection
___ Surgeries
___ Infections and Skin Rashes
___ Anti-Coagulant Treatment
___ Any Progressive Inflammatory
___ Piercings
___ Other (explain below)

___ Diabetes
___ Epilepsy
___ Hypertension/Blood Pressure
___ Pacemakers
___ Radiation Treatment
___ Photosensitivity (Tetracycline)
___ Immuno-Suppressed
___ Any Metal Pins/Plates
___ Phlebitis (Red, Hot Calves)
___ Long Term Cortisone/Prednisone
___ Blood Disease
___ Tattoos
___ Medical Implants

_____
_____
_____

Please check the following reasons you have for using Fine-Light/Acu-Clear:

___ Unhappiness with appearance
___ Want to reduce medications
___ Special occasion
___ Confidence

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and **initial your agreement**.

___ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected.

___ I am to the best of my knowledge not pregnant. Date of last menstrual period (MM/DD/YYYY): ____

___ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

___ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health condition.

___ I give my consent to be treated with Fine-Light or Acu-Clear and any additional services I may choose to enhance my results.

___ I acknowledge that I have been given a copy of the Fine-Light/Acu-Clear guidelines and price list and that I have read and understood them.

_____ _____

Signature Date (MM/DD/YYYY)