LaserLight
TREATMENT CENTER
Joel S. Erickson, MD

MEDICAL INTAKE FORM

Name: [First] _____ [M.I] _____ [Last] _____ Date: _____

Address: _____ Age: _____ D.O.B ___/___/____

City: _____ State: _____ Zip: _____ ____ Male ____Female

Phone: (H) _____ (C) _____ (W)_____

Email: _____

What are you interested in? Check all you are interested in:

☐ Facial Veins ☐ Hand Veins ☐ Leg Veins ☐Skin Tightening ☐ Rosacea ☐Hair Removal
☐ Wrinkles, Sagging Skin ☐Redness or Brown Spots ☐ Uneven Skin Tones ☐ Acne/ Acne Scarring
☐ Enlarged Facial Pores ☐ Sun/Age Spots ☐Botox ☐ Dermal Injectable Fillers

Other: _____

This information is necessary for your procedure. Please answer Yes or No to the following questions:

Yes No

__ __ Are you using any prescribed medications? If yes, please list: : _____
__ __ Are you taking any Photosensitive medications: if yes please list:_____

**Please specifically advise us if you take any of the following medications (circle below):

Accutane, Adapine, Aldomet, Anafranil, Asedin, Aventyl, Benadryl, Capoten, Cardizem, Cipro, Desyrel, DTC-Dome, Elavil, Eulexin, Fluoroplex, Folex, Gold, Lamprene, Loniten, Ludiomil, Norpramin, Periactin, Procardia, Surmontil, Tetracycline, Tofranil, Velban, Vivactil

__ __ Are you using any herbal medications? If yes, please list: _____
_____
__ __ Do you take oral anti-coagulant (blood thinning) medications?
__ __ Are you allergic to any medications and/or foods? If yes, please list: _____
_____
__ __ Are you allergic to any cosmetic ingredient? If yes, please list: _____
__ __ Do you smoke? How much? _____ How Long? _____ When did you quit? _____
__ __ Do you drink alcoholic beverages? If yes, choose one:
☐ Never ☐ Rarely ☐ Weekly-to-monthly ☐ Daily
__ __ Do you spend a lot of time outdoors or use a tanning bed often?
__ __ Do you have any tattoos or permanent makeup? If yes, please list where: _____
__ __ Do you have body piercings? If yes, please list where on the body: _____

YES NO

__ __ Do you have any neuromuscular or autoimmune diseases. If yes, describe: _____

_____

__ __ Do you have a fear of needles? _____

__ __ Do you have any allergies to latex? _____

__ __ Do you have any neuromuscular or autoimmune diseases.
If yes, describe: _____

__ __ Do you have a pacemaker or ICD?

__ __ Do you have any metal in your head or neck?

__ __ Are you Allergic to the sun? if yes describe: :_____

__ __ Do you have a history of cold sores?

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation? If Yes, please list: _____

Please check any health problems, past or present:

☐ Seizures ☐ Hormonal Problems ☐ High Blood Pressure ☐ Diabetes
☐ Heart Problems ☐ Skin Cancer ☐ Cystic Acne ☐ Lupus/Scleroderma
☐ Hepatitis ☐ Thyroid ☐ Asthma ☐ Cancer ☐ Vasovagal Syncope/Fainting
☐ Other: _____

Do you have any of the following chronic skin disorders?

☐ Psoriasis ☐ Fever Blisters/Cold Sores ☐ Dermatitis ☐ Cold Sores ☐ Sun Blisters
☐ Eczema ☐ Keloid Scarring ☐ Herpes Simplex/Blisters

Have you ever undergone any of the following treatments?

☐ Chemical Peels ☐ Botox or Facial Fillers ☐ Microdermabrasion ☐ Photo Facial or IPL
☐ Laser or Light Treatments of skin ☐ Skin Tightening ☐ Accutane ☐ Cosmetic Surgery
☐ Leg Vein Treatment

If Yes, please explain when and where:_____

Race/Ethnicity: What is your ethnic background: _____

I verify that the above information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Reviewed By: _____ Date: _____

Office Use

This patient is a candidate for all treatments offered at Laser Light Treatment Center

Diagnosis:_____

Joel Erickson, MD:_____

Photos taken: ☐ by _____ Stocking Size:_____

NOTICE OF PRIVACY PRACTICES

At the practice of Joel Erickson, M.D., Laser Light Treatment Center, your privacy is a very important part of our mission and plays a very big factor in your experience. Dr. Erickson and his staff adhere to the highest standards of respecting and protecting patient privacy and the confidentiality of your health care information. Additionally, the team complies with all state and federal regulations regarding the privacy of individual health care information, including HIPPA (Health Care Insurance Privacy and Protection Act), enacted on April 14, 2003.

As of April 14th, 2003 we are required by law to offer you a copy of the "Notice of Privacy Practices" regarding your Personal Health Information (PHI).

Your PHI, also known as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

The "Notice of Privacy Practices" details the following:

- How we may use/disclose your PHI to carry out treatment, payment or health care operations
- How you may request copies of your healthcare information
- How you many verify the accuracy of this information
- How you may request an accounting of certain external disclosures of your PHI

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Please acknowledge that you have been offered a "Notice of Privacy Practices" by signing below:

"I have been offered a "Notice of Privacy Practices" by the office of Dr. Joel Erickson and I fully understand and accept the terms of this consent."

I AUTHORIZE THAT MESSAGES FOR PATIENT PERTAINING TO APPOINTS AND INSTRUCTIONS MAY BE LEFT AT THE FOLLOING LOCATIONS:

at work	cell phone	with spouse / significant other
at home/voicemail	via email	other relative

Signature: _____ Date: _____
(Patient, Parent or Guardian)