

HEIGHTS MEDICAL & LASER CENTRE

PATIENT REGISTRATION FORM

(Please Print)

Today's date: _____

OFFICE USE ONLY: (CHART #) _____

PATIENT INFORMATION

Please indicate with Mr. Mrs. Ms. Male Female

Last Name: _____ First Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home #: _____ Work #: _____ Cell #: _____

Occupation: _____ Employer: _____

Carecard Number: _____ Date of Birth: _____ / _____ / _____
Month / Day / Year

HEALTH INFORMATION

Do you have any drug allergies? No Yes, please list _____

Are you taking prescription drugs? No Yes, please list _____

FAMILY PHYSICIAN

Do you have a family doctor? No Yes, please complete this section

Full name of FAMILY PHYSICIAN: _____

Phone #: (____) _____ City/Province: _____

Do you want a copy of this visit to go to your family physician? No Yes

Date: _____ Signature: _____

IN CASE OF EMERGENCY (LOCAL FRIEND OR RELATIVE, NOT AT SAME ADDRESS)

Contact Name: _____ Relationship: _____

Home#: (____) _____ Cell/Alternative: (____) _____

HOW DID YOU HEAR ABOUT OUR CLINIC? (PLEASE CHECK ONE BOX):

Family/Friend Yellow Pages Internet Close to work/home

Newspaper/ Flyer Other: _____

Please note: It is difficult for the Medical Assistant to give approximate wait times. We do estimate approximately 10 – 15 minutes per patient, but this can vary greatly depending on the complexity of each visit. We would however be happy to advise you, how many patients are currently waiting to see the doctor. 😊

THE HEIGHTS LASER CENTRE

CONFIDENTIAL HEALTH INFORMATION

TO BE COMPLETED IF YOU ARE HAVING ANY TYPE OF FACIAL TREATMENTS:

Do you have: Facial redness? Yes No Area of concern: _____
Wrinkles? Yes No Area of concern: _____
Acne/pimples? Yes No Area of concern: _____
Dryness? Yes No Area of concern: _____
Scars? Yes No Area of concern: _____

Have you had a chemical peel? Yes, when _____ No
Have you had laser resurfacing? Yes, when _____ No
Do you have any current skin infections? Yes, when _____ No

TO BE COMPLETED BY WOMEN ONLY:

Are you currently pregnant? Yes No
Do you have regular menstrual cycles? Yes No
Have you been through menopause? Yes No

TO BE COMPLETED ONLY IF YOU ARE HAVING LASER HAIR REMOVAL:

What area(s) are you wanting Laser Hair Removal? _____
Have you used any the following methods to remove hair?
 Waxing Shaving Electrolysis
 Depillatory cream Threading
 Laser (name of laser) _____

TO BE COMPLETED BY EVERYONE PLEASE:

On occasion there may be Physicians or Technicians-in-Training on site to observe clinic consultations and/or procedures. You may refuse to have outside observers at any time. Do you consent to these physicians or technicians observing your visit at our clinic?

Yes No

Would you like to receive newsletters or promotional information?

Yes No

If yes, would you like to receive the information via email or regular mail?

Regular mail Email: _____

Client Signature: _____ Date: _____

THE HEIGHTS LASER CENTRE

CONFIDENTIAL HEALTH INFORMATION

NAME: _____ DATE: _____

- In order to provide you optimal treatment. Please answer the following questions.

Do you suffer from any of the following:

- | | | |
|------------------------------|------------------------------|-----------------------------|
| Cold Sores | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Genital warts | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Headaches triggered by light | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis A, B, C | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV / AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Keloid scars | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lupus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Migraine Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Psoriasis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid Dysfunction | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you ever suffered from cancer? _____ If yes, when and what area?

Have you had any surgery? When and where: _____

Please list all medical conditions you have: _____

Please list all prescription medications you are currently taking: _____

Have you ever taken Accutane? Yes No

Are you taking HRT or Steroids? Yes No

Have you had your hormonal levels checked? Yes No

Please list any vitamins or minerals that you are taking: _____

Please list any topical products you are using on your face or body: _____

Please list all allergies (medications, products and/or general allergies): _____

Have you recently had sun exposure or been in a tanning bed?

- Yes, if so when: _____ No

Have you ever had sclerotherapy, EVLT, or a phlebectomy? If so, when _____