COMPREHENSIVE LASER
LASER TATTOO REMOVAL

PATIENT INFORMATION

Last name:	First name:	Middle name:	Date of Birth:

Address: (Street, City, Zip)	Phone:	Age:	Gender:

Email:	Occupation:	How did you hear about us?
		☐Google ☐Friend ☐Other(specify):

EMERGENCY CONTACT INFORMATION

Name: Relationship: Phone No.:

CANCELLATION POLICY

At Comprehensive Laser we are dedicated to delivering the highest quality and most efficient services to our patients. When appointments are scheduled, we reserve that time and professional medical staff to provide one-on-one consultations and treatments. If an appointment is missed or cancelled with less than 24 hours advanced notice, this prevents other patients from being treated. **There will be a $50 fee collected for any appointments that are missed, cancelled without 24 hours-notice or no-shows.**
A credit card is required to be kept on file for these fees and will only be charged in the event of the aforementioned cases.

PAYMENT INFORMATION

(Please give your credit card to the receptionist for verification)

Cardholder name (Print)	Card number: - - -	Exp Date: /	CVV Code:	Billing zip code:

I hereby authorize Comprehensive Laser to charge my credit card in the amount of $50 for the terms disclosed in the cancellation policy. (Sign below)
Cardholder Signature:_____ Date:_____

MEDICAL HISTORY

Are you currently being treated for any medical condition(s)? NO YES If yes – please specify:

Do you currently suffer from or have ever been treated for any of the following?

☐Arthritis
☐Bleeding disorder
☐Clotting disorder
☐Cancer
☐Diabetes
☐Herpes Simplex Virus
☐HIV/AIDS
☐Keloid scarring
☐Lupus
☐Melanoma
☐Other:_____

Medications

Are you currently using any of the following?

☐ Accutane
☐ Antibiotics
☐ Birth control pills
☐ Hormone replacement
☐ Other: _____

Are you using any topical creams, lotions, gels or ointments?

☐YES
☐NO

Allergies

Are you allergic to any of the following?

☐ Aspirin
☐ Bacitracin
☐ Food
☐ Latex
☐ Lidocaine
☐ No known allergies
☐ Other: (specify)_____

(Female patients only)
Are you currently: ☐ Breastfeeding ☐Pregnant

Smoking status:

☐ Current smoker ☐ Never smoked

I certify that the medical history and information provided above is true and correct. I understand that it is my sole responsibility to update the medical staff of Comprehensive Laser of any changes to my medical condition throughout the course of treatment. I understand that withholding information regarding my medical history can lead to potential injury.

Patient name: (Print) _____ Signature:_____ Date: _____