DeLeon Wellness Medical Center

1546 Kingsley Ave. Orange Park, Florida 32073

Phone: (904) 579-4616 Fax: (904) 579-4962

New Patient Registration Form

Name: _____

(Last) (First) (Middle Initial)

Address: _____ Apt #: _____

City: _____State: _____ ZIP: _____

Home Phone #: ( ) _____ Cell Phone #: ( ) _____

Work Phone #: ( ) _____ Date of Birth: _____

Email: _____

Sex: □ Male □ Female

Emergency Contact

Name: _____ Relationship: _____

Home Phone #: ( ) _____ Cell Phone #: ( ) _____

_____ _____ _____

Patient Signature Print Name Date

Medical History and Cosmetic Interest

Please answer ALL the following questions as honestly as possible; this will help us serve you better

Skin Care Questions:

1. Are you taking any aspirin products or blood thinners? Yes or No
2. Are you presently using Retin A. Renova or Accutane? Yes or No
3. Are you using Glycolic Acid or Alpha Hydroxy Acid? Yes or No
4. Have you recently undergone a chemical or skin peel? Yes or No
5. Are you allergic to any fragrances, oils or topical anesthetics? Yes or No
6. Are you allergic to Aspirin? Yes or No
7. Have you had skin tumors, skin cancer or melanoma? Yes or No
8. Do you have any skin disorders? If so please Describe on Bottom Yes or No
9. Do you have any open sores, herpes, or fever blisters? Yes or No
10. Have you ever had a reaction to skin care products? Yes or No
11. Do you have sensitive skin or bruise easily? Yes or No
12. Have you had any waxing/electrolysis in the last 2 weeks? Yes or No
13. Have you had any permanent cosmetics done? Yes or No
14. Do you have any scars/keloids from surgery or skin grafts? Yes or No

Provide explanations below for each questions answered with "Yes"

Past/Present Medical History

1. Are you or could you be pregnant? Yes or No
2. Are you using birth control pills? Yes or No
3. Are you nursing? Yes or No
4. Are you sensitive to cold temperatures? Yes or No
5. Do you smoke? How many cigarettes a day? Yes or No
6. Do you drink Alcohol? How many glasses daily? Yes or No
7. Have you had a recent physical? Yes or No
8. Are you currently using any bleaching cream? Yes or No

Provide explanations below for each "yes"

Are you currently being treated for any specific condition? Yes or No
Please explain: _____
_____

Are you Allergic to any medications? Yes or No
Please list medications: _____
_____

Are you on any medications? Yes or No
Please List all medications: _____
_____
_____

What are your main areas of concern that brought you in today?
_____
_____

Date of last sunburn? _____ Do you use tanning beds? Y or N

When you go out into the sun, do you (please circle):

1. Always burn
2. Usually burn
3. Sometimes burn
4. Rarely burn
5. Very rarely burn
6. Never burn

I attest that the above information is true and accurate. If there are any changes to my condition or anything related to my medical history I will promptly inform the technician and the office staff in writing so that they are aware.

_____ _____
Patient or legal guardian signature **Date**

_____ _____
Patient or legal guardian print name **Date**

_____ _____
Witness Signature **Date**

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Laser Hair Removal Post Treatment Care

1. Immediately after treatment the hair follicles will turn red and they present swelling, which may last up to two hours, or even longer. The treated area will feel sunburn for a few hours after treatment.
2. The technician may offer an optional cooling method to ensure comfort and relief.
3. A topical soothing skin care product such as Aloe Vera gel can be applied after treatment if desired.
4. Make up can be used immediately after treatment as long as the skin is not irritated.
5. Avoid sun exposure to reduce the chance of hyperpigmentation (darker color).
6. Use a sunblock (SPF 30+) at all times throughout the course of the treatment.
7. Avoid using any other hair removal treatment products or similar treatments such as waxing, electrolysis or tweezing. That will disturb the hair follicles in the treatment areas. Please wait 4-6 weeks after treatment is performed. Shaving is allowed.
8. Anywhere between 5-14 days after treatment expect shedding of the hair. This is not new hair growth. You can clean and remove the hair by washing or wiping the area with a wet cloth of Loofa sponge.
9. For patient's that are getting their underarms treated, the use of powder instead of deodorant is recommended for 24 hours after treatment, it will reduce the skin irritation.
10. There are no restrictions on bathing, just be careful with the treated area for at least 24 hours. Treat the skin as if you have a sunburn.
11. Return to the office or call for an appointment at the first sign of the hair growth. This should happen between 4- 6 weeks for the upper body and possibly as longs as 2-3 months for the lower body. Hair regrowth occurs at different rates depending on the area of the body. New hair growth will not occur for AT LEAST three weeks after the treatment.
12. Contact our office at (904) 579-4616 with any questions or concerns you may have.

_____ _____ _____ _____

Patient or legal guardian signature Date Technician signature Date

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Financial Policy, Consent and Authorization Form

_____ There will be a $50.00 charge for all procedures including Botox, Juvederm, Voluma Etc. not canceled within 24 hours. Please allow at least 48 hours in advance to cancel or reschedule any set appointments.

_____ For Laser Patients, If an appointment was canceled in less than 24 hours of your appointment you will forfeit one laser session.

_____ All patients who purchase a promotion or certificate from Deleon Wellness Medical Center must provide at least 48 hours advance notice before canceling any visit. Any patient that fails to provide this notice will forfeit that specific visit.

_____ There is no guarantee that one treatment will be sufficient to treat a particular area. Each additional treatment, if required, may entail additional charges.

_____ All medical treatments entail risk including, but not limited to: lack of improvement, reaction to medications and worsening of condition. The procedures offered by our office may involve bleeding, bruising, scarring, infection and numbness. As a patient of this practice, you understand that these risks are inherent in the practice of medicine and that you wish to receive treatment.

_____ All patients must be 18 years or older unless accompanied by the parent or legal guardian.

_____ All sales of products, treatments, or services are final.

_____ _____

Patient Signature Date

_____ _____

Office Staff Member Print Name Date