MD Cosmetic - Laser Center

1990 Central Park Avenue
Yonkers, New York 10701
914 793 9143

PATIENT INTAKE FORM for MEDICAL COSMETIC TREATMENT:

Name _____ Birth Date ____/____/_____ Age ____

Address _____

City _____ State _____ ZIP _____

Home Tel. _____ Work Tel. _____ Cell_____

Email Address _____

Emergency Contact _____ Tel._____

How Were You Referred to our Practice _____

Have you ever had any Medical Cosmetic Treatments? _____

What was your experience with them? _____

Please check off the procedures which are of interest to you.

Botox _____ Photorejuvenation _____ Vein Treatment_____
Cosmetic Fillers____ Hair Removal _____ Microdermabrasion_____
Others (please specify) _____

Have you had any of the above treatments previously? _____

Medical History:

List any Medical Problems That You Have _____

List any Medications That You are Taking_____

List Any Allergies That You Have_____

Patient Signature _____ Date _____

MDCosmetic-Laser.com