

# East West Laser Concepts Patient Registration

NAME: \_\_\_\_\_

FULL ADDRESS: \_\_\_\_\_

\_\_\_\_\_

HOME PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US?

\_\_\_\_\_

SSN: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE \_\_\_\_\_

PLEASE CHECK ALL THAT APPLY:

PREGNANT \_\_\_\_\_ EPILEPSY \_\_\_\_\_

CARCINOMA \_\_\_\_\_ THYROID DISORDER \_\_\_\_\_

TAKING IMMUNE SUPPRESSANT DRUGS \_\_\_\_\_

PHOTOSENSITIVE \_\_\_\_\_ LIGHTSENSITIVE \_\_\_\_\_

RECENT BOTOX INJECTIONS \_\_\_\_\_

RECENT STERIOD, ANTI-INFLAMMATORY  
DRUGS OR INJECTIONS \_\_\_\_\_

TAKING MEDICATIONS THAT YOU WERE TOLD TO AVOID THE  
SUNLIGHT \_\_\_\_\_

I hereby guarantee payment of all charges which is due at the time of treatment. I understand that no guarantee is being made by East West Laser Concepts LLC as to the success of the treatment and no refunds will be given:

Signature \_\_\_\_\_ DATE \_\_\_\_\_