

Parker Laser and Anti Aging Clinic

Zerona, YOLO (Lipolaser) and TPR Client Information

Personal History:

Patient _____ Date _____

Date of Birth _____ Occupation _____

Address _____ City _____ State ____ Zip _____

Cell Phone _____ Home Phone _____

Emergency Contact Name and Phone _____

Medical History:

Are you under the care of a physician? Yes No

Please explain _____

Do you smoke? Do you drink?

Do you have any of the following medical conditions? Yes No

- | | |
|--|--|
| <input type="checkbox"/> Cardiac Problems (pacemaker or defibrillator) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Bleeding Disorders or Bruise easily | <input type="checkbox"/> Keloids/scarring |
| <input type="checkbox"/> Do you take anticoagulants or aspirin? | <input type="checkbox"/> Impaired healing |
| <input type="checkbox"/> Diseases stimulated by light (epilepsy, lupus) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diseases stimulated by heat (herpes simplex) | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Skin disorders or Skin lesions | <input type="checkbox"/> Frequent Cold Sores |
| <input type="checkbox"/> Hormone imbalance (PCO) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> HIV/AIDS | |
| <input type="checkbox"/> Other medical conditions? Please explain: _____ | |

Medications: _____

Do you take herbal supplements? _____

Allergies: _____

Have you ever had an allergic reaction to the following: (please circle)

Latex Food Lidocaine Hydrocortisone Anesthesia Topical Anesthetic Other _____

Please explain _____

Female patients: Are you pregnant? Are you breastfeeding?

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The Cold Lasers have no known side effects, except during detoxing. During detoxification, death could be a side effect, if your heart is not healthy.

ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and have been told there are no known risks; although unknown risks may exist and reactions may occur. I hereby release Tina Long, Tracy Paral, Nicole Cox, Susan Elliott and Timothy Judd, MD the referring physician from all liabilities associated with the above indicated procedure. This release holds harmless Parker Laser and Anti-Aging Clinic LLC and Parker Day Spa LLC as well as the above mentioned technicians and voluntarily executed and shall be binding upon myself, spouse, relatives, legal representatives, heirs, administrators, successors and assignees.

Client/Guardian Signature _____ Date _____

Laser Technician Signature _____ Date _____

My initials acknowledge Parker Laser Clinic and Parker Day Spa's 48 Hour cancellation policy. An \$85 fee will be accessed for all appointments not given this courtesy. This will automatically be put on your credit card. Should we have no credit card on file, you will be accessed this fee on your next appointment.

_____ Initials