TOTAL VEIN CARE
AT CORINTH LASER CENTER ANGEL A. RODRIGUEZ, M.D.

Demographics

Patient Name:_____Today's Date_____

Address: _____

City, St, Zip _____

Primary Phone: _____ Cell: _____ Work:_____

DOB: _____ Social Security #: _____Male/Female_____

Email:_____ Occupation:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Work Status: ☐ Full-Time ☐ Part-Time ☐ Self- Employed ☐ Retired ☐ Unemployed

Place of Employment: _____ Referring Physician: _____

Emergency Contact: _____Phone:_____

How did you hear about us: ☐ Newspaper ☐ Magazine ☐ Internet ☐ Friend ☐ Billboard

Insurance Information

Primary Insurance _____

ID# See Card _____Group#_____ Subscriber Name _____

Relation to Patient_____ Subscriber Birth date _____ Subscriber SS#_____

Secondary Insurance _____

ID# See Card _____Group#_____ Subscriber Name _____

Relation to Patient_____ Subscriber Birthdate _____ Subscriber SS#_____

Family Doctor _____ Phone # _____

Are you currently being treated by any other physician(s)?
☐No ☐Yes *(If Yes; Please list with phone number)*

Date of last physical exam:_____

GENERAL HEALTH INFORMATION

Are you currently under a physician's care ❑ yes ❑ no
Have you had any surgery in the past 12 months ❑ yes ❑ no
Present medications _____
Allergies _____
Do you take vitamins ❑ yes ❑ no
Do you or any family members have any history of:
❑ Heart problems ❑ High blood pressure ❑ Diabetes ❑ Thyroid problems
❑ Excessive bleeding or scarring ❑ Epilepsy ❑ Other_____
Past/Present illnesses _____
_____

SKIN ANALYSIS

How would you best describe your skin?
❑ oily ❑ normal to oily ❑ normal ❑ normal to dry ❑ dry
Have you ever had a facial? ❑ yes ❑ no
Have you ever had a chemical peel? ❑ yes ❑ no Type_____
What type of products do you currently use?
❑ cleanser ❑ moisturizer ❑ toner ❑ sunscreen ❑ creams & serums
Do you use Retin-A, Renova, Alpha hydroxy or Glycolic ❑ yes ❑ no
Have you ever been in the sun, tanning bed, or used self tanners? ❑ yes ❑ no If so,when_____
Are you or have you ever used Accutane? ❑ yes ❑ no If so,when?_____ For how long?_____
Have you had any of following in the past or present ?
❑ Botox Last treatment_____
❑ Collagen/Restalyn Last treatment_____
❑ Waxing Area & when_____
❑ Electrolysis Area & when_____
❑ Laser treatments Last treatment_____
What services and treatments are you interested in?_____

Please check the one box which best describes your reaction to sun exposure:
❑ Skin Type I Never tans, always burns (extremely fair skin, blonde/red hair)
❑ Skin Type II Occasionally tans, usually burns (fair skin, sandy to brown hair, green/brown eyes)
❑ Skin Type III Often tans, sometimes burns during first exposure to sun (medium skin, brown hair)
❑ Skin Type IV Always tans, never burns (olive skin, brown/black hair)
❑ Skin Type V Never burns (dark brown skin, black hair)
❑ Skin Type VI Never burns (black skin, black hair)

OTHER HEALTH CONDITIONS

If you have any of the following health conditions, consult with your physician about laser therapy.
Please check any box which describes your current health condition.
❑ Pregnancy ❑ Nursing females ❑ Photosensitivity disorders ❑ Herpes (active)
❑ Shingles (active) ❑ Seizure disorders triggered by light ❑ Bacterial infections

Signature _____ Date _____