

MDCosmetic - 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 _____