VeinTherapies

Laser Skin and Vein Solutions

W. Clark Beckett, M.D., F.A.C.S.

3770 7th Terrace, Suite 102 * Vero Beach, Florida 32960 * 772.567.6602 * Fax 772.567.7754

DATE:_______________________ **PATIENT EMAIL:**______________________________
(to receive emails on our latest laser information)

How did you hear about us? (circle one) **Friend Press Journal Physician VB Magazine**

Other________________

SECTION A: PATIENT INFORMATION

NAME:

LAST________________________________FIRST______________________________INITIAL_______

STREET ADDRESS____

CITY____STATE___________________ZIP CODE_______________

HOME PHONE_____________________CELL PHONE__________________DATE OF

BIRTH_____________

SECONDARY ADDRESS____

CITY__________________________ ST________ZIP_____________PHONE_____________________________

PATIENT SOCIAL SECURITY #___________________________________MARITAL STATUS____________

PERSON RESPONSIBLE FOR BILL___________________________REFERRED BY_____________________

EMPLOYER______________________________________OCCUPATION________________________________

STREET ADDRESS________________________________CITY___________________ST_____ZIP__________

PHONE #___________________________________

SECTION B: SPOUSE INFORMATION

NAME___________________________________DATE OF BIRTH_____________SOC.SEC.#________________

EMPLOYER____OCCUPATION_____________________

STREET ADDRESS_______________________________CITY___________________ST_____ZIP_________

HOME PHONE____________________________________CELL PHONE________________________________

SECTION C: IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME___________________________________RELATIONSHIP________________PHONE_____________

RELATIVE ______________________________RELATIONSHIP______________PHONE_____________

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Medical History
Dermal Fillers

Name____Date_______________________

DOB____________________________________Age_________

Primary Physician's Name and Phone Number____
____

Please list all medications you are currently taking:____
____

List all vitamin supplements you are on:____
____

List all Allergies:____

Circle any of the following illnesses you have or have ever had in the past:

Multiple severe allergies/ Hypersensitivity to medications   Allergy to lidocaine

Autoimmune Disease   History of Cold Sores

List any other medical conditions not listed above that you currently have or have had in the past:
____
____
____

Previous Hospitalizations/Operations:
____
____

Female: Are you pregnant, trying to get pregnant, or lactating (nursing)? ___________________________

Have you had Plastic Surgery or other surgery to your face/neck areas? When? ____________________

Have you had any Dermal Filler procedures before? ____________________ If yes, what? __________
Were you satisfied with the results? ____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to VeinTherapies as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient signature ____ Date: ______________