Randy Tate, M.D.
CENTRE FOR FACIAL PLASTIC SURGERY

Please fill out all information as completely as possible. This information will help us in processing your office visit and make your visit a smoother, quicker and more efficient process.
Thank you!

PATIENT INFORMATION

Name:_____ Date of Birth:_____

Address:_____ Sex:_____ Age:_____ _

City:_____ State:_____ Zip:_____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

Employer Name:_____ Occupation:_____

ADDITIONAL INFORMATION

What is the chief complaint that brought you to the doctor's office:
_____

Who referred you to our office/Referring Source? _____

Your e-mail address:_____ (For Medical Records purposes)

Receive our cosmetic newsletters/e-mail? Yes ❑ No ❑

Are you currently using Latisse for eyelash growth? Yes ❑ No ❑

Are you interested in Latisse for eyelash growth? Yes ❑ No ❑

EMERGENCY CONTACT

Person to notify (in case of emergency):_____

Relationship:_____

Phone #:_____

LASER

Have you been treated by laser in the past? Yes ❑ No ❑
Are you interested in laser treatment? Yes ❑ No ❑

Are you currently on a skin care system? For example: Retin A (or any Retinal products) Yes ❑ No ❑

_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Centre for Facial Plastic Surgery to release any information required to process my claims.

_____ _____
Patient Name Date

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Medical History (Laser)

Name: _____ Date of Birth: _____ Date: _____

Have you ever had any of the following?

Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre-cancerous lesions? Yes ❑ No ❑

Are you pregnant? Yes ❑ No ❑

Any active infection? Yes ❑ No ❑

Disease which may be stimulated by light, such as history of recurrent Herpes Simplex, Systemic Lupus Erythematosus or Porphyria? Yes ❑ No ❑

Use of photosensitive medication and/or herbs that may cause light sensitivity, such as Isotretinoin, tetracycline, Accutane, Retin A or St. John's Wort? Yes ❑ No ❑

Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications? Yes ❑ No ❑

History of hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes.
Yes ❑ No ❑

History of bleeding coagulopathies, or use of anticoagulants? Yes ❑ No ❑

History of keloid scarring? Yes ❑ No ❑

Severe exposure to sun or artificial tanning during the 3-4 weeks prior to treatment?
Yes ❑ No ❑

Do you wear contact lenses? Yes ❑ No ❑

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Name: _____ Date of Birth: _____ Date: _____

What medications do you take? (Including aspirin products and any herbal products)_____
_____
_____

Skin Type:

When exposed to the sun **without protection** for about one hour;

Always burn, never tans _____
Always burn, somewhat tans _____
Sometimes burn, sometimes tans _____
Always tans _____
Hispanic, Asian, Mediterranean, Middle Eastern, Black_____

Allergies: _____

Do you smoke? No❑ Yes ❑ (How much per day)
_____
_____

ACKNOWLEDGMENTS

- I AGREE TO THE FINANCIAL POLICY FOR DR. RANDY TATE OF THE CENTRE OF FACIAL PLASTIC SURGERY.

- *I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE "NOTICE OF PRIVACY PRACTICES" (HIPPA) FROM DR. RANDY TATE'S OFFICE*

- *I UNDERSTAND DR. RANDY TATE IS LICENSED BY THE MEDICAL BOARD OF CALIFORNIA.*

Patient Signature: _____*Date:*_____

Submit