

Lazure Clinique
103 - 45793 Luckakuck Way
Chilliwack, BC V2R 5S6

(604) 824-9797

Patient Registration Form

Mr/Mrs/Miss _____

First name Middle name Last name

Male / Female Status: Single Married Divorced Widowed (pls circle)

Date of birth: _____

How would you like to be addressed? _____

Street address/Mailing address: _____

City: _____ Postal Code: _____ - _____

Home phone: _____ Work phone: _____

Mobile Phone: _____ E-mail: _____ @ _____

How would you like to be contacted? _____

May we leave a message? Y / N May we send you mail? Y / N

Reason for visit? _____

Referred by: (e.g.; physician/Friend-Family/Newspaper/Radio) _____

MSP#: _____ (for B.C. medical covered consultations eg; acne)

Acknowledgement (Signature): _____

Authorization for treatment (please sign) _____

Authorization to photograph (please sign) _____

Please advise our staff if you are not a Canadian Citizen

Medical History

Name: _____ Birthdate: _____

(CIRCLE)

- Do you have any reaction to medication or local anesthetic?.....Yes / No
- Do you have high blood pressure?.....Yes / No
- Are you pregnant?..... Yes / No
- Do you form heavy scars <eg; Keloid>?.....Yes/ No
- Do you have frequent infections, boils or cold sores?.....Yes / No
- Have you ever been treated for seizures?Yes / No
- Have you recently had unprotected sun exposure (no sunblock)?..... Yes / No
- Have you ever had excessive bleeding problems?.....Yes / No
- Have you ever had significant emotional anxiety/fears?.....Yes / No
- Have you ever been advised or had psychiatric care?.....Yes / No
- Are you on any medication<eg; presc, over the counter or herbal?.. Yes / No
- Are you currently or have you in the past used Accutane
/ASA /blood thinners AHA or vitamin products?Yes / No

-Other medical conditions? (e.g.; migraines, bruise easily, diabetes, lupus, thyroid, pigmentation problems, psoriasis, HIV, aids, hepatitis, cold sores, shingles, heart or lung conditions, epilepsy, please list):

-Recent hospital admissions (last 5 years) and reason:

Past surgeries: _____

Past cosmetic procedures: _____

Social history:

Cigarette smoke?.....Yes / No

Second hand smoke exposure?Yes / No

Alcohol?.....Yes / No

Family history (list any medical problems): _____

Are you planning any holidays in the sun? Yes / No... When: _____

Signature: _____

Date: _____