LA Laser-Like Lipo

100 W. Imperial Ave. Ste. N
El Segundo, CA 90245
424-262-4871

Intake Form

Date: _______________

Name: ____

Address: ______________________________________

City: ________________________________ State: _______ Zip: ____________

Birth date: ______________ Age: _____ Sex: M F

Home Ph: ______________________ Cell Ph: ______________________

Text Reminders: Yes No Best Number to contact you: Home Cell

Email Address:_______________________________

circle one: single married widowed divorced separated

Occupation:______________________________

Whom may we thank for referring you or how did you hear about us? (Circle all that apply)

Website Facebook Google

Person______________________ Other_____________________

Possible Contraindications

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

Currently Pregnant?	Yes	No
Thyroid Problems?	Yes	No
Cancer	Yes	No
Pacemaker	Yes	No
Metabolic Disorder	Yes	No
Breast Feeding	Yes	No

Your signature below indicates that you understand that you are solely responsible for any treatment rendered in this office. All services rendered to you are charged directly to you, and you are personally responsible for payment.

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. You understand the above information and guarantee this form was completed correctly to the best of your knowledge and understand it is your responsibility to inform this office of any changes to the information you have provided.

Signature: ____ Date: ________________________