Orchidia Medical Group

Patient Name: _____

Date: _____ Sex: _____Date of Birth:_____/_____/_____

Best Contact Number: (_____)_____ E-mail:_____

Address:_____City: _____

State: _____ Zip:_____ Occupation: _____

Emergency Contact: _____ Phone Number: (_____)_____

How did you hear about us?

Television Radio Magazine Friend Newspaper

Other:_____

MEDICAL HISTORY

Check, If you have any of the following:

Hypertension Heart condition Diabetes
Migraine Asthma Epilepsy Latex allergic
Herpes labialis/Cold sores

Other: _____

Are you allergic to any medications? Yes _____ No _____

Explain: _____

Do you take Coumadin, Heparin, Aspirin, Plavix? Yes _____ No _____

List all medications that you are taking now:_____

_____

Did you have any surgeries before? Yes _____ No _____

Explain:_____

Are you breastfeeding? Yes ____ No ____

When was your Last Menstrual Period:_____

Check if you ever had any cosmetic procedures like:

Botox/Dysport Fillers (Restylane, Juvaderm) Chemical peel Mesotherapy Laser
Other: _____ Are you using any skin products? Yes ____ No _____
wich: _____

Do you produce keloids/excessive scarring? Yes_____ No _____

PAYMENT AGREEMENT Payment is due at the time of service unless other arrangements were made in advance. We only accept debit/credit cards and cash. We do not accept checks.

Return Policy

Unused products in the original packaging may be returned within 14 days for a full refund.

SIGNED _____ Date _____