ORANGE
Cosmetic & Laser Center

JAY APPLEBAUM, M.D., INC. • WIEKE H. LIEM, M.D., INC. • KAROL DANGARAN, M.D., INC.
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Patient Name: _____ Birthdate: _____ Sex: _____

Home Phone Number: _____

Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Would you like to receive emails regarding specials? Yes _____ No _____

(Optional):

Occupation: _____ Work Phone: _____

Business Address: _____

Emergency Contact: _____ Relationship: _____

Address: _____

Emergency Contact Number: _____

Who referred you to this office? _____

Are you allergic, or have you reacted badly to:

1. Local Anesthetic…… yes no
2. Penicillin …… yes no
3. Codeine or other pain killers …….. yes no
4. Aspirin …….. yes no
5. Others …… yes no