

# ORANGE

Cosmetic & Laser Center



JAY APPLEBAUM, M.D., INC. • WIEKE H. LIEM, M.D., INC. • KAROL DANGARAN, M.D., INC.  
MARY S. JUNG, M.D., INC. • SARAH E. STANOWICZ, M.D.

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 \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

Are you currently taking any medication (ex: Accutane or Antibiotics)? \_\_\_\_\_

Are you tan right now (includes self-tanners)? Last date of sun exposure: \_\_\_\_\_

Any tattoos (includes skin-colored tattoos) or permanent makeup? \_\_\_\_\_

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 |