Erin Meier, CMM
Permanently Perfect Cosmetics, LLC
Under Supervision of Dr. Mendy Terrell, MD of Terrell Clinic

ACCENT LASER: Medical History

Name:				Date:	
Birthdate:	Age:	Male/Female	Marital Status:	Height:	Weight:
Address:			Cell Phone: May we leave a Message? Yes / No Home Phone: May we leave a Message? Yes / No Work Phone: May we leave a Message? Yes / No		
Email Address:			Referred By:		
Emergency Contact:			Emergency Contact Number:		
Physicians Name:			Physicians Number:		
Employer:			Job Title:		

Medication/ Supplementation

List current medications (or those you have taken within the last year).

Medication Name	Dosage	Date Started	Date Stopped

Nutritional supplements, vitamins, herbs, homeopathic remedies taken: _____

_____

Phone: 405.302.0060
Fax: 405.302.0066
5025 Gaillardia Corporate Place, Suite E
Oklahoma City, OK 73142
Info@TerrellClinicOKC.com
www.TerrellClinicOKC.com

Medication, Environmental, and/or Food Allergies:

_____

Please Check All That Apply:

- Currently Pregnant
- Wear Contact Lenses
- Very dry skin
- Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre-cancerous lesion such as multiple dyplastic nevi.
- Any active infections
- Diseases which may be stimulated by light at 515nm to 1200nm, such as a history of recurrent Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria
- Use of photosensitive medication and/or herbs that may cause sensitivity to 515nm to 1200nm light exposure, such as isotretinoin, tetracycline, or St. John's Wort
- Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications
- Patient History of hormonal or endocrine disorders such as Polycystic Ovary Syndrome (PCOS), or diabetes, unless under control
- History of bleeding coagulopathies or use of anticoagulants
- History of keloid scarring
- Exposure to sun or artificial tanning during the 3-4 weeks prior to treatment

Alcohol History:

- I never drink alcohol.
- I drink occasionally or socially.
- I regularly drink _____ alcoholic drinks per day.
- I have a family history of alcoholism.

Skin Type:

Please choose the best answer that describes your skin when exposed to the sun **without protection** for about 1 hour:

- Always Burns, Never Tans
- Always Burns, Sometimes Tans
- Sometimes Burns, Sometimes Tans
- Always Tans

Please choose the best answer that describes you:

- Black
- Caucasian/White
- Hispanic, Asian, Mediterranean, Middle Eastern

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When were you last exposed to the sun, including a tanning booth? _____

Do you use chemical sun tanning lotions? _____

Are you planning a holiday in the sun? _____

AREA(S) TO BE TREATED:_____

Prior Treatments, if any: _____

Accent XL Informed Consent Form

I understand that the Accent XL is a radio-frequency device (RF) intended for use in dermatologic and general surgical procedures for non-invasive treatment of wrinkles, rhytides, cellulite and fat reduction. I understand that multiple treatments may be required and that there is no guarantee that the wrinkles, rhytides, cellulite, and/or fat will be completely removed. I understand that there is a possibility of short term (few seconds to hours) adverse effects such as a heating sensation, erythema and dry skin. Burns may occur in rare situations. These possible adverse effects have all been fully explained to me. _____ (please initial)

I understand that the treatment by the Accent XL system involves a series of treatments and the fee structure has been fully explained to me. _____ (please initial)

I understand that there are other options for wrinkles, rhytides, cellulite and fat reduction treatments that are available and each of these other options have been fully explained to me. _____ (please initial)

With this in mind, I am choosing to try Accent XL non-invasive treatment for wrinkles, rhytides, cellulite and fat reduction. _____ (please initial)

Photographs: I give permission for photographs and other audio-visual and graphic materials to be used for marketing and education-promotion purposes. Although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos. _____ (please initial)

I have read and understand this agreement and all of my questions have been addressed and answered to my satisfaction. I agree to the terms of this agreement.

Patient's Name: _____

Signature: _____Date: _____

Laser Tech: _____Date: _____

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