



1002 Mendocino Ave.
Santa Rosa, Ca. 95401
707-577-8292

TODAY'S DATE _____

NAME _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

AGE _____ BIRTHDATE _____

E-MAIL ADDRESS _____

May we use this email address to notify you of specials and updates from Dr. Lacombe? Yes No

EMPLOYER _____ BUSINESS PHONE _____

May we use these numbers to contact you? _____

If not what number can we use to contact you? _____

NEAREST FRIEND OR RELATIVE TO CONTACT IN CASE OF AN EMERGENCY

NAME _____

HOME PHONE _____ CELL PHONE _____

FAMILY DOCTOR _____ PHONE _____

Which procedures are you interested in discussing today? _____

How did you hear about Artemedica? (please check box & specify)

Patient Name: _____ Newspaper: _____

Radio: _____ Doctor: _____

Social Media: _____ Salon: _____

Internet/Website: _____ Other: _____

BY INTIALLING BELOW, I UNDERSTAND THAT A \$50 SPA BOOKING FEE WILL BE COLLECTED IN THE CASE THAT I NO-SHOW OR CANCEL MY SPA APPOINTMENT WITH LESS THAN 24 HOURS NOTICE. _____initials



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NAME: _____ DATE _____

MEDICATIONS AND DRUGS

Allergy to any Drug or Medications: (specify):

ALLERGIC TO IODINE? _____ BETADINE? _____ LATEX? _____

Approximate daily consumption of: Tobacco _____ Alcohol _____

Please list all medications that you currently take. (Prescription and over-the-counter)

1.	4.
2.	5.
3.	6.

Pharmacy Name: _____

PAST MEDICAL HISTORY

General Health: Good _____ Fair _____ Poor _____

If not "Good" please explain:

Height _____ Weight _____ Date of last physical check-up: _____

Serious illnesses (please list):

Do you have a history of cold sores? YES NO

PREVIOUS SURGERIES (including cosmetic procedures)

Type of Operation	Year
1.	
2.	
3.	
4.	

Have you ever had significant complications or after effects from these or any other surgeries? YES
NO